TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development, Implementation Science, and Evaluation

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CHAPTER

13

BPSO HOST: A MODEL FOR SCALING OUT GLOBALLY

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify how the BPSO Host Model has addressed evidence-based practice gaps internationally
- Describe the multifaceted strategies for knowledge translation developed and used under the BPSO Host Model
- Outline the impact of the BPSO Designation in different health system contexts

INTRODUCTION

Evidence-based practice is considered a methodological paradigm that serves as a reference for common criteria to be used in clinical decision-making. In this context, the Nursing and Healthcare Research Unit (Investén-isciii) and the Spanish Centre for Evidence Based Nursing and Healthcare applied to become a BPSO (Best Practice Spotlight Organization) Host, to initiate the BPSO Designation at the national level. This chapter describes the organization of the BPSO Host Model in Spain, as well as the strategies and process used in its development. The BPSO Designation in Spain currently has two active cohorts, one of BPSOs initiated in 2012 and designated in 2015, and a second cohort of BPSO candidates initiated in 2015. The next cohort of BPSO candidates will start in 2018. The BPSO Designation is demonstrated to have an impact on health structures, organizational challenges, and process and patient outcomes. Overall, the participating organizations have achieved a change in culture, shifting to one that is oriented to evidence.

NURSING CARE IN THE SPANISH HEALTH SYSTEM

Spain's 17 regions, or autonomous communities (CCAA), are part of the Spanish National Health System, which is configured as a coordinated group of health services of the Administration of the State and Health Services of the CCAA. The National Health System integrates all of the health provisions and functions that, according to the law, are the responsibility of the national authorities, while transferring other areas to the CCAA. Therefore, the central government has authority over the basic legislation, which affects the entire Spanish population and the coordination of the responsibilities of the CCAAs. The major aspects of the central government's responsibilities include health financing, pharmaceutical policy, international policies, as well as everything related to the education of specialist professionals.

Meanwhile, the CCAA are competent in subsidiary financing and legislation; the deployment of public health in their territory; the organization of their health system; and aspects regarding accreditation, planning, purchase, and provision of services.

The Spanish National Health System is characterized by its universal integration; it is publically financed through taxes and provides integral care to the population. It has a specific portfolio of services, including the co-payment of nonhospital pharmaceutical prescriptions and a system of evaluation. It is decentralized in the CCAA and organized in levels: mainly primary care, specialized care (hospital), and long-term care. In 2012, the Royal Decree-Law 16/2012 introduced into law severe cuts to the Spanish National Health System. In 2015, the Spanish National Health System (NHS) had a total of 164,385 nurses, being the largest group of health professionals, with a ratio of 1.5 nursing professionals for every physician. Hospitals employ the highest number of professionals—77,446 physicians and 134,743 nurses—while the primary care level employs 34,900 physicians and 29,642 nurses. The ratio of professionals per 1,000 inhabitants remains stable, with almost 0.6 professionals per 1,000 inhabitants in primary care, and 2.9 per 1,000 inhabitants in hospital care.

Within the Spanish health system, nurses hold an important role in the delivery of health services in primary care and in hospitals. Efforts to systematize the transfer of best available evidence into nursing clinical practice are common country-wide across hospital and service delivery settings, led by different

institutions. However, in the early 2000s, the use of evidence-based guidelines in practice was found to vary considerably, contributing to undue differences in the quality of services delivered.

THE SPANISH EXPERIENCE OF IMPLEMENTING RNAO BPGS

The Spanish National Nursing and Healthcare Research Unit (Investén-isciii) belongs to the Institute of Health Carlos III, the main Public Biomedical Research Entity at the national level. One of the objectives is to incorporate nursing research into daily clinical practice.

Our concern was the variability in nurses' clinical practice within our national health system and its influence on safety and the quality of services provided. Approaches to evaluation of nursing practices were not comparable across regions, or even across institutions, which constrained the ability to systematically monitor service delivery. Previous efforts to increase and sustain the use of evidence-based guidelines in the delivery of health services in Spain had relatively limited success. In spite of this, Spanish nurses perceive knowledge translation as a priority (Comet-Cortés et al., 2010).

In 2010, as a means to both address variations in care delivery and quality of care and to improve service quality, the Nursing and Healthcare Research Unit formally partnered with the Registered Nurses' Association of Ontario (RNAO) to influence and evaluate the uptake of nursing BPGs across healthcare organizations, to enable practice excellence and positive client outcomes. The Nursing and Healthcare Research Unit became a Best Practice Spotlight Organization (BPSO) Host, responsible for overseeing the implementation of RNAO's BPSO Designation in Spain (Grinspun, 2011).

To reach clinical professionals, depending on each regional health system, our first strategy was to have the support of the Spanish Centre for Evidence Based Nursing and Healthcare. This is a nationwide center, established in 2004 and led by the Institute of Health Carlos III through the Spanish Nursing and Healthcare Research Unit, with 16 regions participating. The Collaborating Centre aims to promote and support the synthesis, transfer, and utilization of evidence through identifying feasible, appropriate, meaningful, and effective healthcare practices to assist in the improvement of healthcare outcomes globally. The Spanish BPSO Host is coordinated by the national Nursing and Healthcare Research Unit (Investén-isciii) and the Spanish Centre for Evidence Based Nursing and Healthcare (www.evidenciaencuidados.es).

REFLECTION

How does this context impact the BPSO Designation process in Spain? What kinds of strengths and challenges are apparent that may have to be addressed in the BPG implementation process?

BUILDING A SUCCESSFUL INITIATIVE

RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION SPAIN/ESPAÑA

RNAO Best Practice Guidelines focus on nursing care and integrate not only practice recommendations, but also education, organization, and policy recommendations. BPGs are thus aligned with the Spanish National Quality Plan (Plan de Calidad para el Sistema Nacional de Salud), which addresses quality from practice, education, and policy perspectives (Ministerio de Sanidad, Política Social e Igualdad, 2010). In addition, RNAO has experience with BPG implementation through: hosting a number of BPSO cohorts in Ontario,

Canada; developing and using an evidence-based implementation tool (RNAO, 2012); and providing training and ongoing support. The conditions in Spain were also favourable, as the Spanish BPSO Host is supported by two strong and prestigious structures, very well known by Spanish nurses and other stakeholders.

The Spanish BPSO Designation is based on four key strategies:

- **Translation of BPGs into Spanish**—Investén-isciii signed an agreement with RNAO to translate RNAO's Best Practice Guidelines for use in the Spanish context, and in partnership with RNAO established the criteria for quality guidelines translation.
- **Dissemination**—RNAO provides online access to BPSO Designation information. BPSO launches promoted through the media and marketing of informative sessions are means to draw attention to the opportunity of participating. BPSOs in Spain are called "Centros Comprometidos con la Excelencia en Cuidados" (CCEC).
- **Implementation and evaluation**—The Spanish BPSO Host launched the first call for proposals through a competitive application process to select healthcare settings in Spain for implementing the RNAO's BPGs and evaluating the results (Ruzafa-Martínez et al., 2011). The approach is nursing-led and multidisciplinary, multipronged in strategy, context-specific, and involves a wide range of stakeholders. The RNAO (2012) *Toolkit: Implementation of Best Practice Guidelines* guides the process with a train-the-trainer approach, selection of recommendations to be implemented, a 3-year schedule of planned implementation activities, and monitoring by measuring process and outcome results for patients.
- **Sustainability**—As the regional host for Spain, Investén-isciii supports the maintenance and scaling-up of BPG implementation, and creating a national network of BPSOs to join the international BPSO network overseen by RNAO.

REFLECTION

Consider how the four key strategies that are part of the BPSO Host plan reflect the Knowledge-to-Action framework and successful change processes.

OUR FIRST COHORT

Out of 33 organizations responding to the call, eight health-care settings (involving 11 sites, providing care to 1.3 million of people) were selected. They are located in seven different regions and include hospitals as well as primary healthcare centers.

The BPSOs selected are:

- Centro de Salud Ponferrada II (G.A. P. Bierzo)
- Complejo Hospitalario de Universitario de Albacete
- Hospital Clínico San Carlos
- Hospital Doctor José Molina Orosa
- Hospital Medina del Campo
- Hospitales de Sierrallana y Tres Mares (G.A.E. Áreas de Salud Torrelavega-Reinosa)
- Hospital Rafael Méndez de Lorca junto con la Universidad de Lorca
- Hospital Universitario Vall d'Hebrón

As one of the BPSO Leads said:

> *"To be selected [as a BPSO] it's a very important motivation to change our nursing practices and to demonstrate that small organizations can do big things."*
>
> –Mª Angeles González; G.A. P. Bierzo

Overall, the BPSOs implemented 10 BPGs, according to the needs at each institution.

The most-selected BPGs were:

- *Ostomy Care and Management* (RNAO, 2009)
- *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011)
- *Breastfeeding Best Practice Guidelines for Nurses* (RNAO, 2003)
- *Assessment and Management of Pain* (RNAO, 2013)

> *"When guidelines were not aligned with areas of improvement identified by nurses and other professionals, they were not so innovative and engaging as they are when there is alignment."*
>
> –Mª Luz Fernández; Hospitales de Sierrallana y Tres Mares

From 2012 to 2014, BPSO candidates engaged and trained health practitioners in implementing the selected guidelines, reviewing and updating protocols and procedures, monitoring and evaluating their utilization, and reporting data to the Nursing and Healthcare Research Unit and RNAO (Albornos-Muñoz, González-María, & Moreno-Casbas, 2015; González-María, 2014; World Health Organization [WHO], 2015). Upon successfully attaining all of the deliverables, they earned their BPSO Designation in 2015. Designated organizations continue to receive support from the National Unit for Nursing Research and RNAO, and renew their designation every 2 years, based on successful achievement of required deliverables.

While organizations receive considerable support from the BPSO Host (the Nursing and Healthcare Research Unit), they are ultimately responsible for ensuring the implementation of guidelines within their own organization. Each organization is required to designate an overall BPSO Designation leader, the BPSO Lead, as well as a leader for each guideline to be implemented. In addition, all senior management within the organization must sign the BPSO Agreement with the National Unit for Nursing Research to demonstrate widespread managerial support for becoming a BPSO. A group of health practitioners is selected by organizations to become Champions for each guideline; it is up to organizations how many are recruited, as long as they fulfill the minimum of 15% of nursing staff stipulated in the Agreement. Champions are trained by the National Unit for Nursing Research on BPG implementation and how to motivate peers to utilize BPGs in practice.

Training was provided through a train-the-trainer model, whereby a group of guideline Champions is appointed at each participating institution and receives a weeklong, formal training program on implementing the RNAO guidelines, motivating practitioners to use guidelines, and monitoring performance. Additional training is offered annually because building staff capacity is recognized as an ongoing process that continually needs updating. Champions are then responsible for training health practitioners in their respective organizations and supervising adherence to guidelines.

For the evaluation component of the program, "Data Dictionaries" have been developed to document and report on the Nursing Quality Indicators, which are specifically related to each BPG and used to assess RNAO BPG implementation.

As BPSO Host, we provide considerable support to our BPSO Directs in a number of ways. Besides the initial training of BPSO leaders, there is continuous follow-up to guide the implementation and monitoring process. Monthly meetings, regular review and feedback on evaluation results, and annual audits provide windows to understanding the progress of each BPSO, enabling us to support them on their specific needs. This relationship of follow-up and exchange is highly acknowledged by BPSO leaders:

REFLECTION

In your view, what factors in the implementation process spurred the remarkable uptake of BPSO by organizations, the full engagement of nurses, and the sustained interest in this work across Spain? How could these factors be replicated in your setting?

> *"Many things are new for us, but we don't feel alone; the support from the BPSO Host helps us to keep focused so we don't lose direction."*
>
> –Emma Alonso; Hospital Doctor José Molina Orosa

In addition, we promote knowledge exchange between BPSOs, encouraging networking between and amongst organizations with similar characteristics implementing similar BPGs.

> *"We were not used to working with health organizations belonging to different regional health systems; this approach gives a new perspective and is a powerful tool."*
>
> –Pilar Pérez; Hospital Universitario Vall d'Hebrón

OUR SECOND COHORT

In late 2014, a second open call for BPSO candidates was issued, and 10 out of 60 organizations, representing 70 healthcare sites across Spain, were selected to begin implementation in 2015. The selected BPSO candidates are:

- Hospital Universitario Donostia
- Complejo Hospitalario de Navarra
- Área de Salud de Menorca

- Consorcio HUAV-HSM-Facultad enfermería Lleida
- Hospital Universitario Puerto Real
- Complejo Hospitalario Universitario de Granada
- Organización Sanitaria Integrada Debabarrena
- Centro de Salud José María Llanos
- Gerencia de Atención Integrada de Alcázar de San Juan
- Hospital Valle de Nalón

At this time, 16 BPGs are currently being implemented, taking into account both cohorts. Figure 13.1 shows the distribution of BPSOs in both cohorts in Spain, with the figures in the bold representing Cohort 2. Figure 13.2 shows the complete list of selected BPGs, as well as how many BPSOs in each cohort are implementing each one, with the figures in bold representing Cohort 2. All in all, 19,100 health professionals in 193 units are involved in the BPSO initiative in Spain. They have 1,200 Champions, and they are working with thousands of collaborators. Together they collect data on 35,983 patients and serve a population of 4,478,050.

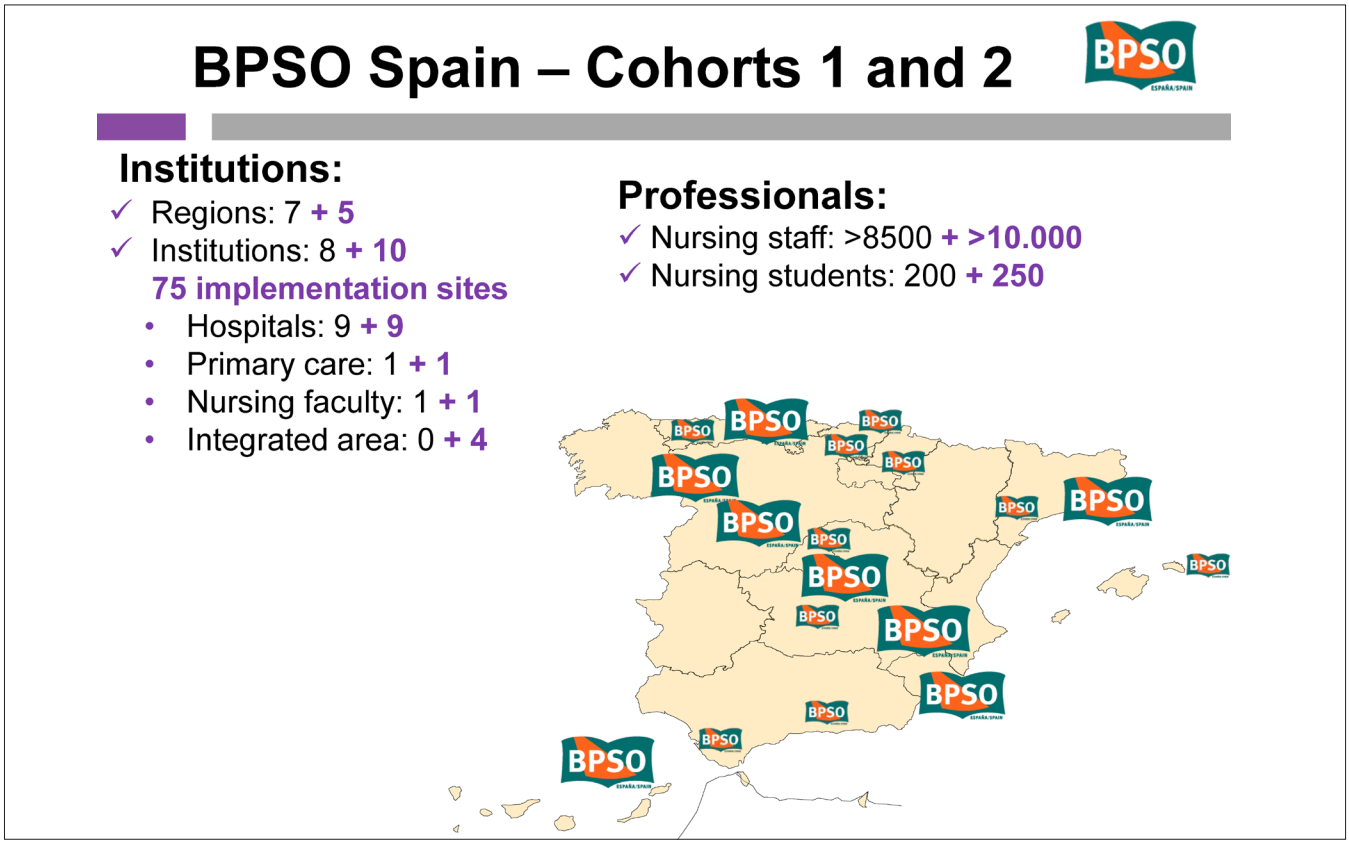

FIGURE 13.1 BPSO cohorts 1 and 2 in Spain.
Used with permission.

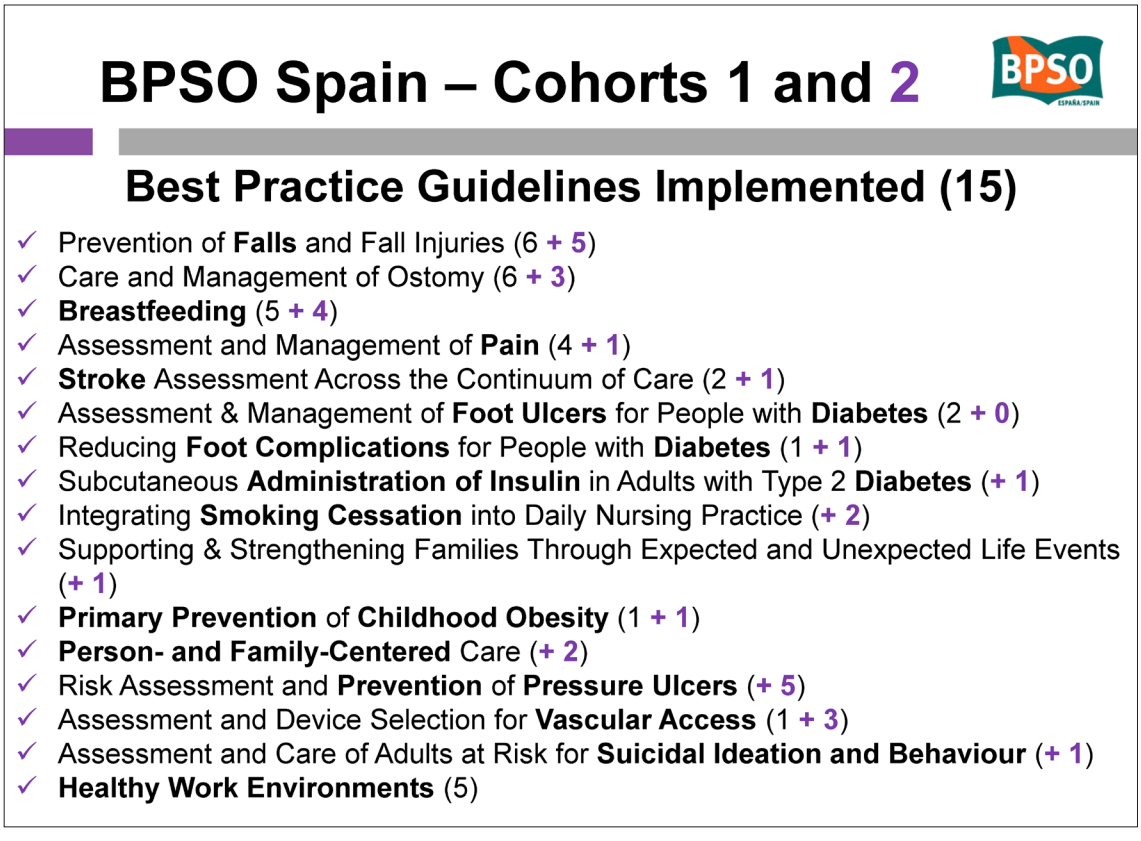

FIGURE 13.2 BPGs implemented by BPSO cohorts 1 and 2 in Spain. Used with permission.

While the characteristics of the organizations in the new cohort differ from the first one, the feelings of leaders and Champions continue to be encouraging. The following quotes represent their outstanding successes.

"It's so amazing to observe how three organizations who previously worked separately are working together for a common objective . . ."

–Mercè Folguera and Josep María Gutiérrez; Consorcio HUAV-HSM-Facultad enfermería Lleida

"Champions are developing actions unthinkable one year ago."

–Cristina Torres; Organización Sanitaria Integrada Debabarrena

REFLECTION

How do you think Cohort 2 benefitted from the experiences of the first cohort? What did the BPSO Host do to encourage this?

OVERALL STRATEGIES

Table 13.1 depicts a summary of the common strategies carried out by BPSOs.

TABLE 13.1 COMMON STRATEGIES FOR EFFECTIVE BPSO IMPLEMENTATION

AREAS	OBJECTIVES	ACTIVITIES
Training	■ Design and deliver continuous training in implementation methodology ■ Design and deliver continuous training in relation to guideline topics	■ Design different modalities of training (online, face to face, express) ■ Develop training plans for guidelines ■ Involve Champions
Implementation	■ Develop the operations of implementation teams in relation to the selection and adoption of recommendations ■ Establish an action plan developed by healthcare professionals of units ■ Collect and mobilize implementation strategies suggested by units, and disseminate to all groups ■ Increase adherence to recommendations ■ Follow up and support implementation teams on the development of strategies	■ Assess modalities (by subgroups, etc.) ■ Establish different mechanisms for implementation (e.g., pilot vs. recommendations) ■ Establish different mechanisms for communication ■ Assess barriers and strategies ■ Strategize for professional compensation
Exchange Sessions	■ Meet periodically to discuss successes, challenges, and strategies with the healthcare professionals of the units ■ Create external alliances ■ Participate in a wider network of external groups (regional, etc.)	■ Facilitate systems for meetings and communication ■ Plan and schedule meetings ■ Promote multicenter studies, clinical residency, exchanges, etc.
Evaluation Planning	■ Evaluate using a common method ■ Minimize variability amongst evaluators ■ Provide systematic and multilevel feedback ■ Maintain a continuous system for evaluation and improvement	■ Develop documentation manuals and mechanism of translation to electronic records ■ Develop a coordination plan for evaluation and feedback ■ Identify new indicators to evaluate
Dissemination	■ Ensure multilevel dissemination of the project	■ Create a dissemination group ■ Design a dissemination plan that include different processes and channels

REFLECTION

Consider how you might use the implementation strategy chart presented above. What strategies would work well in your setting and why?

EVALUATION PROCESS

Evaluation is one of the key pillars of the program. The information obtained allows the Host to know the degree of implementation, as well as the impact on patients' health. The systematized feedback to different stakeholders is one of the most appreciated mechanisms amongst those involved.

> *"Evaluation and feedback at the unit level are an essential element. Champions who participate on the evaluation team share results with their colleagues and contribute to development of new solutions for improvements."*
>
> –Lucía Gárate; Hospital Universitario Donostia

RNAO's Nursing Quality Indicators for Reporting and Evaluation (NQuIRE) provides the evaluation mechanism and process to monitor BPG implementation by BPSOs. To adapt evaluation to country requirements, the Spanish BPSO Host developed a specific database, CarEvID, to measure the structure, process, and outcomes of BPG implementation in Spanish organizations. Together, RNAO and the Spain BPSO Host have analyzed the minimum data set applicability and established procedures to transfer data from the national nursing database CarEvID to the international platform NQuIRE.

Similar to NQuIRE, the CarEvID database integrates indicators at three levels to provide comparative reports. The first level is composed of *structure data*, which includes nursing hours, model of care delivery, and organizational profile of the institution and unit level. Structure indicators have been internationally defined as to reflect staffing and other human resource–type data that should be collected at the level of the implementation site. The second level includes the minimum data set of *process and outcomes-based quality indicators*, currently related to 16 Best Practices Guidelines. Forty-two process and 30 outcome indicators are part of the common minimum data set and are evaluated internationally following the same definition of indicators, variables records, and procedures. At the third level, *national or local data* are collected and processed. These outcome and process indicators present specificities, such as being part of national programs, not being included in national records, or following different collection procedures.

All BPSOs collect baseline data from the month prior to their official beginning as BPSO candidates. Data are collected subsequently during the last 5 days of every month, except for low prevalent cases, such as ostomy, in which case all patients are measured. Descriptive analysis of variables is carried out by CarEvID.

CarEvID includes more than 8,000 records related to falls prevention, 3,000 records of assessment and management of pain, 1,500 records related to breastfeeding, 700 records related to ostomy care, and 200 records related to stroke assessment. This database is perceived by the BPSOs as an important way to network:

How can the evaluation data shown in this chapter be best used to spread the BPSO Designation and sustain the efforts of the early cohorts in Spain?

"Use of common indicators, measured in the same way, reinforces our ability to learn from each other in the network."

–Pilar Rodríguez; Hospital Medina del Campo

In terms of impact, currently 18 facilities in Spain contribute to the growing NQuIRE database, which can now be used to show impact of implementation. The international component is one of the keys to success:

"The possibility of international benchmarking increases the credibility of the program for the managerial boards that have to sustain it."

–Dolores Quiñoz; Complejo Hospitalario Universitario de Granada

OVERALL IMPACT

There are many areas where we can observe the impact of the BPSO Designation in Spain.

- New organizational structures have been created or promoted, which serve to embed evidence-based culture into the organization.
- More than 3,200 nurses and other healthcare professionals have training in implementation and/or specifically in each BPG's recommended interventions. Their training has resulted in: the harmonization of interventions, the development or update of evidence-based protocols, the promotion of patient education, and the evaluation of international BPSO indicators using an electronic platform.
- One of the most important results is the harmonization of records. Because clinical records are established at a regional level, any change influences all healthcare organizations, thus potentially resulting in a wide spread of BPG implementation in the future.
- Some of the major findings include the improvement of process and outcome indicators. Falls prevention, ostomy care, and breastfeeding were three of the most frequently selected guidelines, by eleven BPSOs, nine BPSOs, and nine BPSOs respectively. Their results in relation to these guidelines showed significant improvements when comparing baseline measures to the 3rd-year post-implementation data as indicated below:
  - Registration of falls prevention assessment (69.4% vs. 80%)
  - Ostomy preoperative assessment and education (31.6% vs. 46%)
  - Preoperative ostomy marking (16% vs. 54%)
  - Reduction of falls (2.2% vs. 1.78%)
  - Improvement of exclusive breastfeeding at discharge (60% vs. 81%)
  - Exclusive breastfeeding at 6 months (29.7% vs. 40.3%)

Scholarly and scientific contributions are another area of success for BPSO participants. In addition to increased participation by Champions in congress and other scientific events, BPG implementation has become a prominent area of study for master's and PhD students currently involved as Champions in clinical BPSOs. The collaborative BPSO network is now being used, amongst other means, to develop research projects. While published research results related to Spain's implementation of BPGs are not yet available, data collection that is currently taking place will allow for outcomes to be evaluated and analyzed.

> *"When we engaged with RNAO in the BPGs implementation program we were very optimistic regarding success, but we never thought it would have such a strong impact."*
>
> –Spanish BPSO Host team; Investén-isciii/Spanish Centre for Evidence Based Nursing and Healthcare

To sum it up succinctly, the overall impact has included:

- Improved access and adherence to BPG-specific evidence-based tools developed for nurses, other health professionals, and patients/caregivers, enabling more comprehensive care
- Improved patient satisfaction
- Introduction of risk assessments for prevention of health issues such as falls and pressure injury, with planning and development involving the interprofessional team, contributing to better uptake and greater satisfaction
- Improvement of records completion
- Establishment of nursing sensitive indicators
- Better coordination and integration of care across different settings

REFLECTION

How can the powerful data in this chapter about Spain as a BPSO Host be used to support the evidence-based practice movement in nursing, the BPSO Designation, and the global synergy in nursing through this work?

CONCLUSION

The Best Practice Spotlight Organization (BPSO) Designation in Spain is multicentered, covers different healthcare sectors (hospital, primary care, long-term care, and nursing homes), and addresses a wide range of healthcare problems. Key to the sustainment of the overall BPSO Designation, including the consolidation of the BPSO network and ongoing establishment of new cohorts, were: the alliances created on the micro and macro levels, continuous evaluation and feedback on implementation strategies, and the dissemination of results and development of related research.

The outcomes reported by our BPSOs and the overall BPSO Designation in Spain demonstrate that the RNAO BPG-implementation methodology can be replicated with success internationally. Strategies developed based on the local context contribute to the program's effectiveness, and, through a consolidated network, these strategies and the relevant BPG and implementation knowledge have been shared across healthcare settings to promote an evidence-based culture that reaches a wide spectrum of health professionals and patients.

KEY MESSAGES

- Scaling up in the BPSO Host Model is influenced by nursing leadership, strategic planning, interprofessional team collaboration, and partnerships, which strengthen dissemination of good practices, reduce unreasonable variability in care, and increase quality.
- Full engagement of nurses in the provision of evidence-based practice and monitoring its impact motivates passion for better performance and advancing people-centered healthcare.
- The BPSO Host Model is a successful approach to spread evidence-based practice and inspire inter-organizational collaboration.
- Evaluation of BPG impact is most effective if it addresses structure, process, and outcomes indicators measured in a consistent way.
- The BPSO Host Model has demonstrated its powerful potential to impact client health outcomes at the local and regional levels, as well as outcomes for nurses, the profession, other healthcare providers, and healthcare organizations.
- RNAO's overall BPSO Designation and implementation methodology, as demonstrated in Spain, can be replicated with success internationally.

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