

# TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development,  
Implementation Science, and Evaluation



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



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

# THE LATIN-AMERICAN BPSO EXPERIENCE: A CONSORTIUM MODEL

*Aracelly Serna Restrepo, BScN*

*Maribel Esparza-Bobórquez, MSc, BScN, RN*

*Sonia Abad Vasquez, MA, BScN, RN*

*Olga L. Cortés, PhD, MSc, CCN, RN*

*Lina Maria Granados Oliveros, MSc, RN*

*Alejandra Belmar Valdebenito, BScN*

*Josephine Mo, BA (hon)*

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

## LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Gain an appreciation for the impact of the RNAO BPSO Designation in Latin America
- Understand processes used to adapt the BPSO Designation to fit local contexts, generating engagement and leading to sustainment
- Explain how key strategies of change such as awareness raising, alignment with organizational values, use of a Champions model, and attention to monitoring and evaluation have facilitated creation of evidence-based practice cultures and collective identity in Latin American BPSOs
- Describe the value of a BPSO consortium approach in BPSO spread, BPG uptake, resource management, innovation, sustainability, and outcomes
- Identify how RNAO has managed fidelity processes of the BPSO Orientation Program and the audit and feedback, along with a train-the-trainer approach, to bolster resources and acknowledge local leadership strengths

## INTRODUCTION

In July 2012, the Registered Nurses' Association of Ontario's (RNAO) Best Practice Guidelines made its formal debut in Latin America when RNAO signed agreements with two facilities in Chile and two in Colombia to become Best Practice Spotlight Organizations (BPSO) Direct. These pioneers are the Universidad de Chile, Escuela de Enfermería, and Clínica las Condes in Chile; and two hospitals—Cardioinfantil Foundation of Cardiology Institute (FCI-IC) and Fundación Oftalmológica de Santander (FOSCAL) in Colombia. They formed the Latin America BPSO Consortium and received together their orientation and Champions training. They committed to a 3-year BPSO qualifying experience, wherein they would focus on enhancing their evidence-based nursing practice and decision-making cultures, with the mandate to implement and evaluate multiple clinical practice guidelines. The Chilean and Colombian organizations chose the guidelines they deemed most beneficial to their patients and students, including those focused on treating pressure ulcers, establishing therapeutic relationships, providing end-of-life care, preventing falls in older people, assessing and managing pain, and developing and sustaining nursing leadership.

The BPSO Direct program is a partnership between RNAO, who acts as BPSO Host, and an academic or health service organization, which assumes responsibility for all deliverables and costs associated with achieving the BPSO Designation. With oversight and support from RNAO, the BPSO Direct builds capacity through training of BPSO Champions; develops and delivers specific implementation activities; engages in regular knowledge exchange, monitoring, planning, and evaluation sessions with RNAO staff; participates in RNAO's NQuIRE database; and utilizes a variety of dissemination methods to share learnings, resources, and achievements with the wider healthcare community.

RNAO's role as BPSO Host is to launch the program with a 5-day orientation based on a systematic implementation and evaluation framework (RNAO, 2012b). Through a train-the-trainer approach, RNAO imparts the knowledge and skills to the BPSO Lead(s) and staff or faculty at the organization, who then train additional Champions and develop a network to support and enhance BPG implementation. The BPSO journey in Latin America started with the formal signing of agreements in July 2012, followed by the Orientation Program, which was delivered in Spanish at CLC to the full consortium (RNAO, 2012a).

Knowledge exchange is key to the success of the BPSO Designation, not only for peer learning and mentorship, but also for cultivating a spirit of individual and collective improvement. Virtual meetings prove to be very effective for RNAO to connect with international BPSOs and support their ongoing activities. The Hispanic consortium has been strengthened by regular virtual meetings every 2 months between the RNAO BPSO mentor to the consortium, CEO Dr. Doris Grinspun; RNAO BPSO Coordinator for Latin America, Josephine Mo; and the BPSO Leads in each country alongside their executive and/or full implementation teams.

The consortium holds annual BPSO research conferences organized by one of the BPSOs on an alternating basis. These conferences serve as another valuable mode of knowledge exchange, included as a deliverable of the program, which brings together all BPSOs in this particular region to present and discuss their strategies and outcomes. Engagement of the media at these events, as well as officials from government and the broader health community, heightens the profile of both the participating organizations and the BPSO Designation, while promoting the value of evidence-based nursing practice (EBP) and the robust contribution nurses are making to patients and organizational- and health-system outcomes.

RNAO also conducts a yearly audit of the BPSOs in Chile and Colombia to ensure program fidelity and progress with implementation of BPGs. The audit is composed of visits to the implementation sites, as well as review of materials related to the structure, process, and outcomes of the program. In addition to dynamic progress with the program, the audits also show a shared and very strong BPSO collective identity and pride. At each of the four institutions there is high visibility of the BPSO logo in units and the availability of BPSO-branded resources everywhere. These act as symbols of inspiration and motivation for nurses and also spark the interest of patients and their families who receive care and education based on BPGs. With its added presence on the organizations' websites and Intranet, the BPSO Designation has attained even greater profile and reach.

The case studies in this chapter explore the perspectives of three BPSOs: Clínica las Condes, Cardioinfantil Foundation of Cardiology Institute (FCI-IC), and Fundación Oftalmológica de Santander (FOSCAL).

## C A S E S T U D Y

### THE EXPERIENCE OF FCI-IC IN IMPLEMENTING RNAO EVIDENCE-BASED GUIDELINES

*Clinical practice guidelines* (CPGs) are a type of knowledge synthesis at the highest level of the literature, with a selection of care recommendations based on the best existing evidence (Dearholt & Dang, 2012). Given the advanced information they contain, they are instrumental in the decision-making of health professionals about specific care situations (Dearholt & Dang, 2012). Clinical practice guidelines review, evaluate, and combine evidence related to problems, while incorporating all relevant aspects and values that determine a clinical decision, such as risk, prognosis, costs, patient values, and institutional achievements (DiCenso et al., 2002). CPGs need to be implemented in real practice situations by caregivers and thus be able to reduce adverse events (e.g., falls) and increase positive indicators (e.g., education) in the target population. This requires professionals with critical thinking and leadership skills who can transform routine care into scientific-based nursing care (Grinspun & Aninyam, 2014).

In order to achieve excellence in care, nurse leaders of the Nursing Department of the Cardioinfantil Foundation of Cardiology Institute—FCI-IC, located in Bogotá, Colombia—entered the Best Practice Spotlight Organization (BPSO) partnership with RNAO through a formal agreement which was signed in 2012. FCI-IC is a private, nonprofit hospital. It has a total of nine hospitalization services for adults and a total of three hospitalization

services for children; 90 intensive care beds, of which 19 are neonates, 20 are paediatric, and 51 are adult; and a total capacity of 340 beds.

The overall purpose of joining the RNAO BPSO Designation was to implement and evaluate three RNAO Best Practice Guidelines (BPG) in selected adult-care services at FCI-IC. Our organization also sought to adapt the RNAO leadership model in the implementation process and evaluate the results in patients under our care. This collaboration included the commitment to submit data on each BPG to NQUIRE, RNAO's global BPG-related indicator data system. This international data set would provide a general reference on the impact of BPG implementation worldwide. Lastly, FCI-IC aimed to promote the progress resulting from BPG implementation in order to demonstrate the importance of evidence-based practice and the advances in terms of quality and patient safety, particularly in a care institution for patients with cardiovascular diseases and risk factors.

Taking into account that nursing care and its effectiveness based on the use of BPGs is not a common practice in Colombia, we were cognizant of how our experience might encourage the understanding of other colleagues about this process. Our case study thus includes a brief description of the implementation methodology, our outcomes during the BPSO predesignation period

(2012–2015), sustainability, leadership, research, and future development.

## SELECTION OF BEST PRACTICE GUIDELINES

The implementation planning process began in mid-2012, after the BPSO Agreement was signed. Training Champions was the first step of processes related to BPG uptake and implementation. Over 10 years of evaluation data at our institution allowed us to have an understanding of the problems related to the incidence of events such as falls, skin pressure ulcers, and foot ulcers in diabetic patients. In order to select the most appropriate BPGs, we needed to identify the priority healthcare problems that we could overcome with the implementation of those guidelines. We performed a baseline diagnostic evaluation through a survey, which identified a number of existing problems. These included issues in the use of diagnostic tools for risk assessment for both falls and pressure ulcers; an underreporting of events in the electronic medical record; a prevalence of falls with injuries; use of bed railings for all patients, with no consideration of patient risks; and a prevalence of grade III and grade IV pressure ulcers. Based on this evaluation, three BPGs were selected: two focused on preventive care, *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011a) and *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b), and the third on *Assessment and Management of Foot Ulcers for People with Diabetes* (RNAO, 2013a). The selection phase lasted 6 months.

## SETTINGS FOR IMPLEMENTATION AND POPULATION

The next phase involved the identification of hospital services for implementing the selected BPGs, including services that provided care for adults ( $\geq 18$  years) and those with a high prevalence of events such as falls, pressure ulcers, and foot ulcers. For the implementation of *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011a), two services were selected: internal medicine-general surgery and cardiology. For the

implementation of *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b), we selected two intensive care units (ICU): medical and surgical. Finally, for the implementation of *Assessment and Management of Foot Ulcers for People with Diabetes* (RNAO, 2013a), we chose to include all adult hospitalization services (eight services in total).

## STUDY AND CRITICAL ANALYSIS OF SELECTED RNAO GUIDELINES

The objective of this phase was to identify the strength of the evidence in each BPG and to select the recommendations with high or medium level of evidence for implementation. We also identified common interventions used routinely in our institution that should not be modified, as well as interventions currently in place that were not based on evidence.

We performed an analysis of the interventions and their levels of evidence (Ia, Ib, IIa, IIb, III, IV) (Scottish Intercollegiate Guidelines Network [SIGN], 2008) and reviewed the recommendations in each of the BPGs. We selected those recommendations that had the best level of evidence, were most needed for services, and could be implemented with our existing hospital resources (material, personal, and administrative). An example of recommendations selected for one BPG is presented in Table 15.1.

Current practice patterns and use of risk scales were evaluated. The instruments for risk assessment were selected for each guideline. They included the STRATIFY Falls Risk Assessment Tool, the Braden Scale for pressure ulcers, and the University of Texas Diabetic Wound Classification. We also obtained the necessary instruments for monitoring and documentation (Fundación Cardio-Infantil IC, 2012). The selected interventions were integrated into our practice and were illustrated in flow charts and diagrams and were part of comprehensive care processes for patients at risk. We needed to learn or to unlearn certain interventions in the change process, such as unlearning the use of guardrails for all hospitalized patients.

**TABLE 15.1 RECOMMENDATIONS SELECTED FROM THE RISK ASSESSMENT AND PREVENTION OF PRESSURE ULCERS BPG**

<b>RECOMMENDATIONS THAT WERE SELECTED FROM RISK ASSESSMENT AND PREVENTION OF PRESSURE ULCERS (RNAO, 2011B) BPG AND IMPLEMENTED</b>		<b>LEVEL OF THE EVIDENCE</b>
Assessment	Perform an initial assessment of the state of the skin from head to toe and subsequently every day for those patients at risk of deterioration of skin integrity.	IV
	The risk of pressure ulcers is determined by combining clinical criteria and the use of a reliable risk assessment tool (e.g., Braden Risk Scale).	IV
	If patients are in bed or seated for long periods or following surgery, pressure, friction, and shear forces should be controlled in all positions. All pressure ulcers are identified and classified according to the NPUAP criteria *. Assessment and management of pressure ulcers in stages I to IV. All data are documented at the time of initial assessment and continuously on a regular basis thereafter.	IV
Planning	A personalized care plan is based on assessment data, risk factors, and goals in order to meet the patient needs. The plan should include the patient, family, and health personnel.	IV
Interventions	Programming of position changes. (For example, with clock use.) Use appropriate techniques during position changes (do not pull the patient across the sheets; position change must be done with the help of other professionals). Assess the pain and take into account the impact.	IV
	Lubricate the skin while avoiding massage and/or friction on bony prominences.	IIb
	Patients at risk of pressure ulcers should not remain on conventional mattresses. A low-pressure high-density foam mattress is used. In the case of high-risk patients undergoing surgical intervention, it is advisable to use pressure relief mechanisms.	Ia
	Establish interventions for patients with bed rest or sitting. Protect and promote the integrity of the skin. Protect the skin from excessive moisture and incontinence. Conduct a nutritional assessment if nutritional deficiencies are suspected.	IV

*continues*

**TABLE 15.1 RECOMMENDATIONS SELECTED FROM THE RISK ASSESSMENT AND PREVENTION OF PRESSURE ULCERS BPG (CONTINUED)**

RECOMMENDATIONS THAT WERE SELECTED FROM RISK ASSESSMENT AND PREVENTION OF PRESSURE ULCERS (RNAO, 2011B) BPG AND IMPLEMENTED	LEVEL OF THE EVIDENCE
Educational program for the prevention of pressure ulcers.	III
Best Practice Guidelines in nursing can be successfully implemented if resources, planning, and administrative and institutional support exist.	IV

\*NPUAP: National Pressure Ulcer Advisory Panel. [www.npuap.org](http://www.npuap.org)

## SELECTION OF OUTCOMES (INDICATORS)

In this phase, the outcomes of each BPG were analyzed, and we carried out structural changes in order to ensure the valid documentation of the information (events and nursing care plans) into the electronic chart. In addition, communication systems (visual or by notes) were structured in the same electronic clinical history in order to convey the risk of each patient (for falls or pressure ulcers) to the medical staff and the interdisciplinary team.

The indicators selected for *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b) were:

- The percentage of admitted patients diagnosed with the risk scale selected (Braden Scale)
- The percentage of patients newly evaluated at 24 hours with the same scale
- Patients at risk for pressure ulcer (%)
- The incidence of grade II to grade IV pressure ulcer (number of patients with new pressure ulcer/clients at risk of pressure ulcer) in a given period of time

The evaluation indicators for the *Assessment and Management of Foot Ulcers for People with Diabetes* (RNAO, 2013a) included:

- The percentage of those patients assessed who received leg assessment
- Percentage of those patients who had a foot ulcer assessment at the time of admission

- Percentage of those patients and families that received education
- Reduction of wound size (ulcer), at least 50% standing

Finally, the indicators for the *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011a) included:

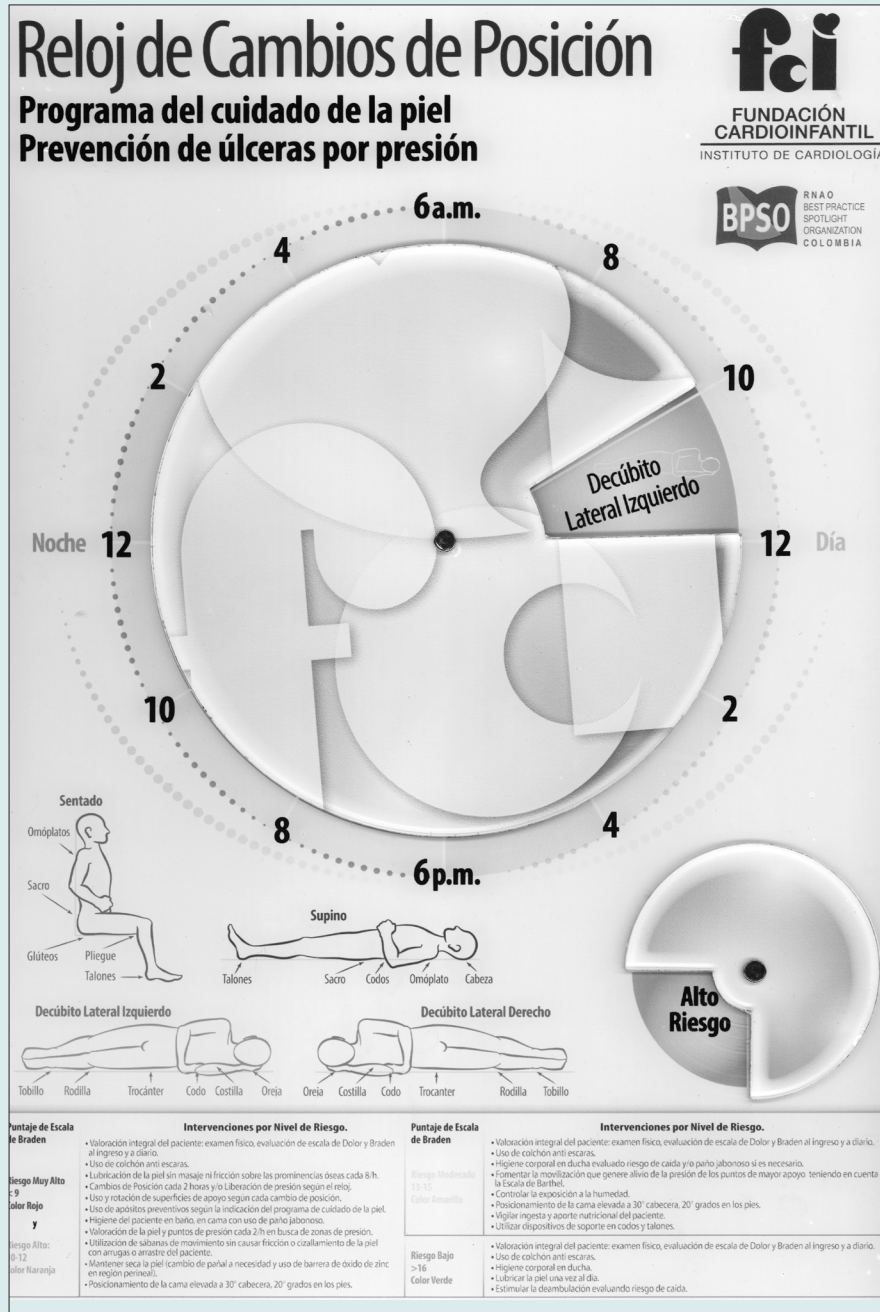
- The percentage of patients diagnosed with risk for falls at the time of admission, using the falls risk scale
- The total number of individuals who entered the fall prevention program
- The percentage of use of guardrails
- The rate of falls (number falls/days/patient) and post-fall injuries

## IMPLEMENTATION AND MONITORING

In order to ensure the successful implementation of the BPGs, we selected spontaneous leaders or leaders with outstanding knowledge of each hospital service. Shift leaders (morning, afternoon, and evening) received training and were motivated with knowledge of the aims and content of BPGs, and also of the assessment of indicators and education strategies, in order to disseminate each BPG. This procedure took into account the RNAO (2013c) BPG, *Developing and Sustaining Nursing Leadership*, and the use of other general educational organizational strategies.

Educational material was developed in order to carry out dissemination sessions in three ways: peer-to-peer, in small groups, and in large groups (see Figure 15.1a and Figure 15.1b). The dissemination sessions included reading meetings, critical case analyses, lectures, and

direct monitoring with staff. Nursing staff (professional, auxiliary, and coordination) and hospital directors were made aware of BPGs and their relevant contents at every opportunity.



**FIGURE 15.1A** BPSO educational materials developed by FCI-IC. Used with permission.



**FIGURE 15.1B** BPSO educational material developed by FCI-IC. Used with permission.

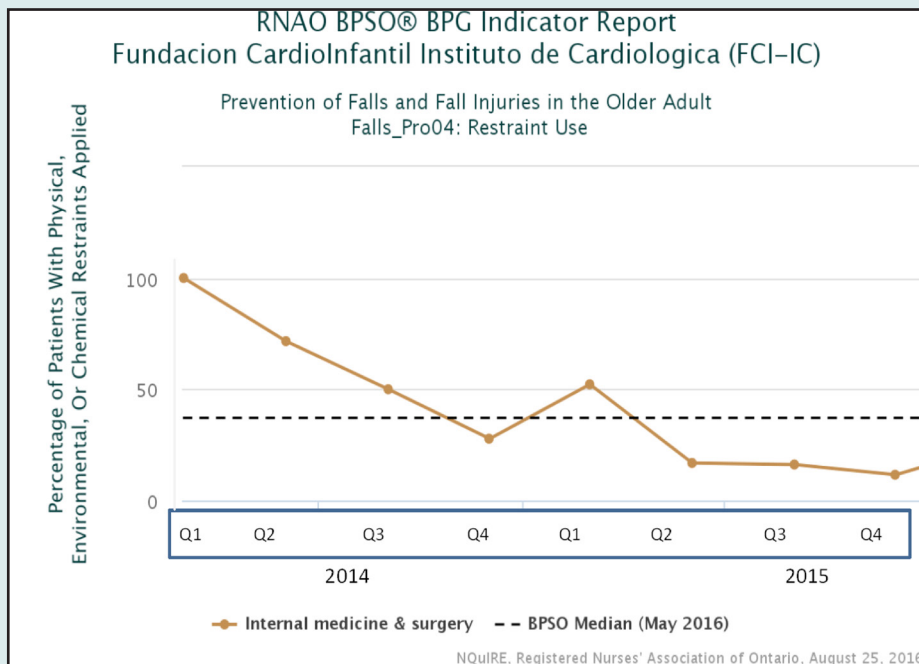
In order to monitor adherence to evidence-based recommendations, adverse events data, and patient outcomes in each of the services, we built formats to collect information related to the screening of patients in the selected services, to identify total population admitted, total population at risk (for falls or for pressure ulcers), in addition to information on the indicators for each BPG. Nursing coordinators of the morning, afternoon, and evening shifts initially collected this information with supervision from the implementation leaders of the falls prevention and pressure ulcer prevention in particular. This information was validated through the use of institutional databases and confirmed in the medical records. Indicator information was recorded in the RNAO database NQuIRE on a quarterly basis.

The entire staff was involved in both the presentations of the BPSO Designation and in the educational sessions related to each BPG. In general, a total of eight institutional BPSO Designation sessions and 10 BPG-specific tutorial sessions were conducted throughout the implementation process. The training of 800 professionals was carried out in six sessions in large groups, and six sessions were organized for only the leaders of the selected

services with a dedication of 30 hours per leader. Interprofessional groups were organized to monitor the adherence to the BPGs, including physicians and other health professionals.

## RESULTS OF BPG IMPLEMENTATION

An evaluation and validation of the BPGs selected and implemented by FCI-IC were conducted for the period between January 1, 2014 and December 31, 2015. The results were obtained from data reported to the NQuIRE database. For the evaluation of the *Prevention of Falls and Fall Injuries in the Older Adult* BPG (RNAO, 2011a), we analyzed 2,208 patients admitted to the cardiology and cardiac surgery services and 4,154 patients in the internal medicine-surgery services up to December 2015. Amongst the most outstanding results of the implementation was the adherence of nursing staff to the use of the Falls STRATIFY risk scale for the assessment of 100% of newly admitted patients. There was also a significant reduction, approximately 80%, in nursing staff's use of handrails with patients at risk for falls (see Figure 15.2).

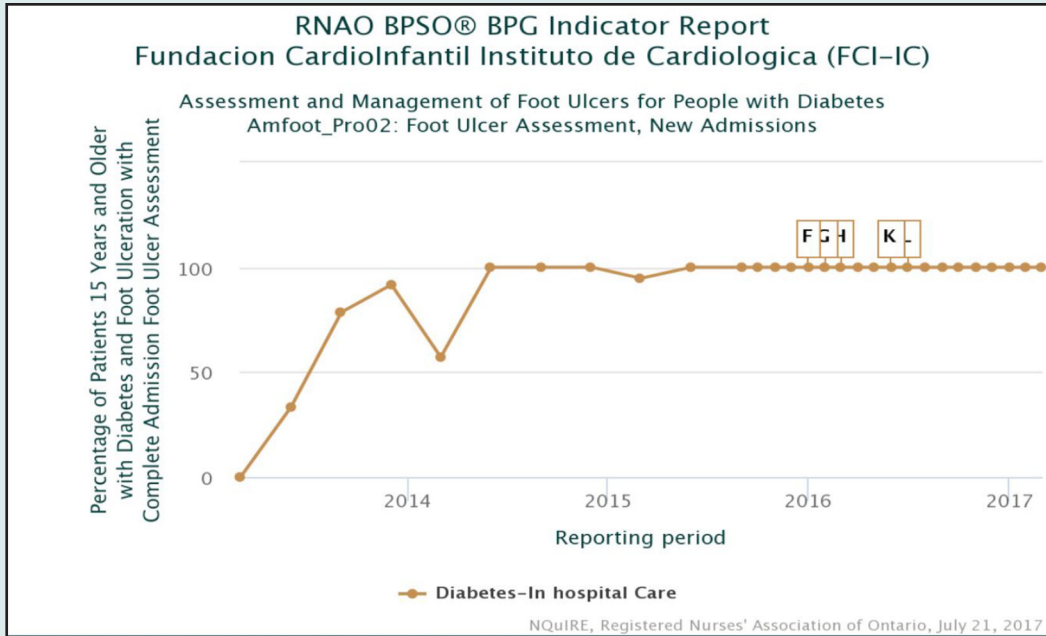


**FIGURE 15.2** NQuIRE reporting on reduction of the use of railings in beds (physical restraints), FCI-IC.  
Used with permission.

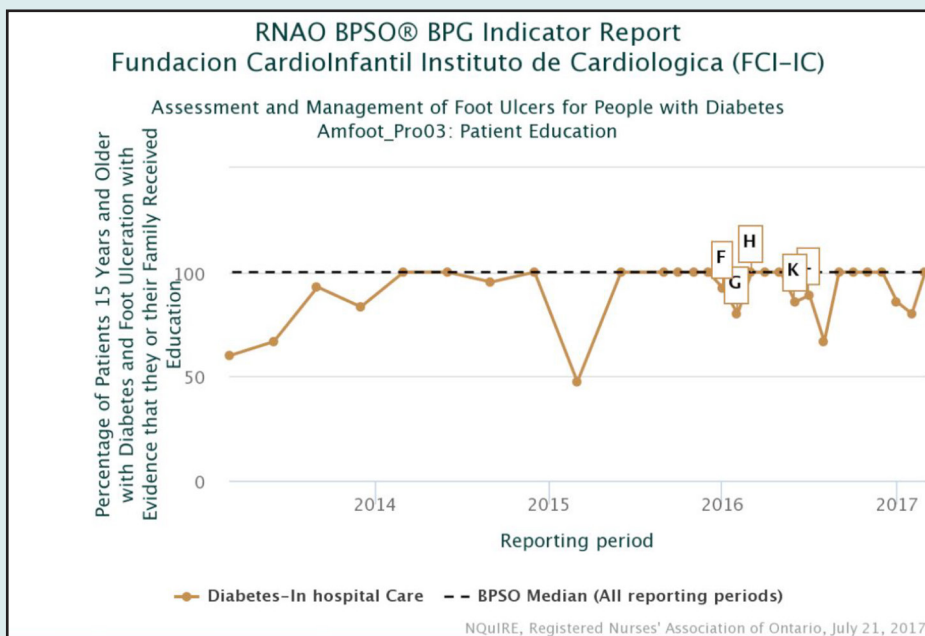
Two intensive care units (one healthcare unit and one surgical care unit) were included in the evaluation of the *Risk Assessment and Prevention of Pressure Ulcers* BPG (RNAO, 2011b), with a total of 5,952 patients admitted. The adherence of the nursing staff was 100% in the use of the Braden Scale with patients at the time of admission and with patients at 24 hours post-admission. One hundred percent of patients had access to “anti-bedsore” mattresses, as part of institutional policy.

Finally, the results of the evaluation of the *Assessment and Management of Foot Ulcers for People with Diabetes*

BPG (RNAO, 2013a) showed a 100% increase in care activities for diabetic patients, such as assessments in lower limbs, assessment of feet and ulcers (University of Texas Classification), and an increase in education given to the patient and their family based on the medical history report (see Figures 15.3a and 15.3b). The assessment of size reduction in a diabetic foot ulcer was 30%. Amputations have limited observation of healing in the short and medium term.



**FIGURE 15.3A** NQure reporting on foot ulcer assessment, new admissions, FCI-IC. Note: The letters F, G, H, and K indicate cases where patients received amputations during hospitalization. Used with permission.



**FIGURE 15.3B** NQure reporting on education to patients with foot ulcers and their families. Note: The letters F, G, H, and K indicate cases where patients received amputations during hospitalization. Used with permission.

## POSITIVE STRATEGIES FOR SUSTAINING THE IMPLEMENTED BPGS

The sustainability of implementation has been planned as part of knowledge transfer (KT). First of all, there are budget-oriented measures to maintain the training of nurses, such as the Champions. Secondly, all education strategies are aimed at new staff and continue to target basic nursing staff in order to maintain the effectiveness of the interventions of each BPG. Finally, there is a solid relationship between the nursing department and the direct-care services that are implementing BPGs, which is strengthened through projects, research, and improvement plans to reduce adverse events.

Strengthening nursing leadership through continuing education, ongoing feedback, and specific education makes it possible to reduce the variability of care. Working teams set goals and prioritize the focus of their care based on continuous improvement using the BPG indicators. This cycle helps sustain the integration of best practices into nursing, thus ensuring improvements in the health experience of patients and their families.

The increased focus on research in this area is promoting scientific development in evidence-based nursing care. One prominent example is the PENFUP study, which focuses the use of skin protectors to prevent pressure ulcers, based on a randomized controlled trial. This study received a grant from the Institute of Science and Technology Colombia (COLCIENCIAS), which was submitted in partnership with RNAO and FOSCAL (BPSO Direct in Colombia). The participation of nursing and health professionals in this project has further promoted evidence-based practice in the prevention of pressure ulcers. We anticipate that final outcomes of the study will augment the evidence in future editions of the *Risk Assessment and Prevention of Pressure Ulcers BPG* (RNAO, 2011b).

## EFFECTING CHANGE THROUGH BPG IMPLEMENTATION: A PERSPECTIVE OF THE NURSING STAFF

In general, the implementation of RNAO BPGs, the ongoing connection with RNAO, and the BPSO and Champions networks have enabled FCI-IC to witness the tremendous

impact of the BPSO Designation on improving care and its outcomes for patients. The quarterly analysis of data from each service has enhanced the understanding of the value of evaluation by demonstrating the impact of interventions on care. The general enthusiasm and individual nurse ownership of this knowledge have contributed to the formation of implementation teams and the identification of new institutional leaders. The visibility of nursing has significantly increased in our hospital as a result of the evidence-based interventions we adopted and the impact of our advances. This has also been a motivation for other teams.

Our participation in the RNAO BPSO Program involves serious, coordinated, and structured work aimed at reducing adverse events in the population under our care. The decrease in the variability of care has allowed us to increase quality standards, in accordance with national and international accreditation assessments.

Likewise, this work has allowed us to strengthen the critical thinking of healthcare providers. The process of organizational implementation has led to improved documentation of events in electronic records and a stronger focus on evaluation and critical analysis of indicators in groups and by services, and has impacted the national and international accreditation assessments.

In terms of continuing education at FCI-IC, the teaching methodology was transformed by including pedagogical models to achieve learning objectives, from induction to specific training programs to maintain the sustainability of interventions. Electronic medical records were transformed by including some of the BPG recommendations on diagnosis, evaluation, and follow-up for individuals and their families. A large body of educational material has been established for staff and the community. This presents the opportunity for further evaluation of such elements and their impact on BPG implementation.

Finally, the collaborative work between FCI-IC and RNAO has triggered several organizational improvements for nurses and nursing care. First, BPGs are now built into institutional policies and have served to enrich our human resource allocation to guarantee the daily physical and emotional well-being of the people under our care. In addition, there is now nursing representation and participation in the decisions related to new acquisitions and changes in infrastructure. The BPGs, policies, and the achievement of better patient and family outcomes

now form part of the strategic objectives and performance of the FCI-IC Department of Nursing (Lucía Cortés et al., 2016).

Finally, the implementation process, as a result of the RNAO guidelines, has guided our nursing practice toward care that is based on the use of best evidence, from assessment of risk, to prevention of adverse events, to interventions leading to better outcomes. As for next steps, we aim to strengthen our nursing research capacity,

as well as the evidence behind BPG recommendations, through further research studies.



## REFLECTION

*What were the key drivers in the success of the BPSO Designation in FCI-IC? What key barriers were overcome and how?*

## C A S E S T U D Y

### THE EXPERIENCE OF FOSCAL IN IMPLEMENTING RNAO EVIDENCE-BASED GUIDELINES

The Ophthalmological Foundation of Santander (FOSCAL) is a tertiary and quaternary care institution, located strategically in the northeast region of Colombia. It has a capacity of 256 hospital beds (229 adults, 19 paediatrics, and 8 obstetrics), 46 beds in the intensive care unit (34 for adults and 12 for paediatric), 18 operating rooms, emergency service, and a parturition center (maternal and child center). On average it handles a volume of 1,584 monthly visits, an average stay of 5.8 days, and a 93% bed occupancy rate, a situation that allows for the presence of risks in the different services and care processes carried out in the institution.

As an institution of this level of complexity, with a serious interest in improving the quality of care, it was necessary to generate a change in nursing care processes. Such a change would require knowledge of different aspects: organizational size and culture, type of care, characterization of the population, problems or weaknesses detected, and, more importantly, the health human resources. The transformation of knowledge within organizations is what generates this change, but where and how do you start toward this goal?

We believed this change could be achieved with the implementation of the evidence-based RNAO Best Practice Guidelines (BPG). In FOSCAL's application to the RNAO

Best Practice Spotlight Organizations (BPSO) Designation, these goals were outlined, and an implementation plan was developed.

### PREPARATION PHASE

This phase consists of a number of the steps required in the BPSO application process, which are highlighted here.

1. **Raising awareness about the RNAO BPGs and BPSO Designation**—The first step in the change process is to share and promote information about the internationally renowned RNAO program, which disseminates evidence-based guidelines to health-care organizations around the world and supports their uptake and implementation. The rollercoaster of change model is a helpful illustration to guide the change process in nursing practice (Haines, 2005).
2. **Establishing a positive approach**—Commitment and enthusiasm from the outset are key factors in the success of the process. The leadership of the organization initiates the process by preparing a letter of intent that outlines their mentoring role to staff and stakeholders and shows keenness to receive the expertise and resources of RNAO.

3. **Commitment**—The letter of intent elaborates on the organization’s goal to participate in the BPSO Program and attain BPSO Designation.
4. **Coordination**—The organization appoints a BPSO leader who will receive BPSO orientation and training in leadership and capacity-building methodology.
5. **Selection of guidelines to be implemented**—Knowledge of critical nursing issues during the care process assists in the review of RNAO BPGs to identify the priorities to be addressed through this methodology. Criteria used for BPG selection include the impact within the care process on nursing, the patient, family, institution, and also the resources available or necessary for implementation. FOSCAL selected the BPGs on *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO,

2011a) and *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b) for their preventative benefits for patients and the institution. The BPG *Assessment and Management of Pain* (RNAO, 2013b) was selected for its systematic approach to care, and quality interventions to provide comfort to patients. The overarching objective was to improve the care of patients.

## VALIDATION OF THE GUIDELINES WITH AGREE II AND AGLI METHODOLOGY

The RNAO guidelines were evaluated with the AGREE II methodology in order to assess their methodological rigor and transparency, and the AGLI methodology to determine the recommendations to be implemented (see Table 15.2).

**TABLE 15.2 EVALUATION OF BPGS WITH AGREE II AND AGLI**

BPG	AGREE II	AGLI
<i>Assessment and Management of Pain</i>	91.3%	Of 18 recommendations, 17 are implementable and 1 is implementable with conditions
<i>Prevention of Falls and Fall Injuries in the Older Adult</i>	89.3%	Of 13 recommendations, 9 are implementable, 2 are implementable with conditions, and 2 are nonimplementable
<i>Risk Assessment and Prevention of Pressure Ulcers</i>	81.5%	Of 31 recommendations, 23 are implementable, 2 are implementable with conditions, and 6 are nonimplementable

## SELECTION OF SERVICES

This phase focuses on locating and prioritizing the issues within healthcare services for the start of the implementation process. Services were selected by performing an environmental analysis and evaluating the prevalence of related events. For skin lesions, pilot implementation of recommendations from *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b) was aimed at internal medicine, neurosurgery, and the adult intensive care unit. The delivery room and oncology were selected to implement the *Assessment and Management of Pain* guideline (RNAO, 2013b). For the *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011a), consistent with the BPSO requirements, hospital-wide implementation was planned, beginning with two internal medicine services.

## SELECTION OF CHAMPIONS

Following the selection of services, key people (BPG Champions) are identified to lead BPG implementation activities and monitoring of adherence to the process. Each of the guidelines has a leader responsible for the transfer of knowledge to the service staff. Champions receive specially designed BPSO pins that recognize their role.

## ORGANIZATION OF EDUCATION FOR CHAMPIONS

This stage involves preparing the themes; identifying demands on faculty, availability of human resources to participate, and logistics of training; and the act of institutional recognition.

## BPSO AGREEMENT

The BPSO Agreement between FOSCAL and RNAO was signed in 2012 for a period of 3 years and includes stipulations related to BPG selection, development of a BPSO infrastructure, capacity building, implementation, dissemination, and evaluation activities. Part of the dissemination requirement of the agreement is the publication of a scientific article on the implementation

experience. To meet this deliverable, FOSCAL published an article in the *MedUNAB* journal (Esparza-Bohórquez, Granados Oliveros, & Joya-Guevara, 2016) entitled “Implementation of Best Practice Guidelines: Risk Assessment and Prevention of Pressure Ulcers: Experience of the Ophthalmological Foundation of Santander (FOSCAL).” Other parts of the BPSO Agreement include organizing an annual international research congress, submitting quarterly reports, participating in the NQuIRE database, undergoing an annual BPSO audit, and motivating other institutions to partake in this methodology.

## ELABORATION AND UPDATE OF PROCEDURES

The existing recommendations in each guideline implemented were reviewed, and the impact; viability; and human, administrative, and economic resource requirements were assessed based on the evidence. The resulting protocols developed are being updated every 2 years, incorporating relevant new evidence from RNAO’s new editions of these BPGs. A logo was designed to identify the services where BPGs were being implemented. These were seen as BPSO Units. See Figure 15.4.

## STAFF TRAINING

The nursing division of FOSCAL and RNAO both conducted training for the BPG implementation teams.

## STAKEHOLDER IDENTIFICATION

Stakeholders were identified by brainstorming who could influence our processes and who would be influenced by them. Then given the role and influence of these staff members and others in the implementation process, it is important to obtain their support for the methodology and identify the actions that various staff groups must carry out.

## SELECTION OF TOOLS

The tools selected to assess the risk of patients for conditions as identified in the different guidelines are shown in Table 15.3.



**FIGURE 15.4** BPSO plaque developed at FOSCAL. Used with permission.

**TABLE 15.3 TOOLS TO ASSESS PATIENT RISK**

**TOOLS**

BPG	Scales
Risk Assessment and Prevention of Pressure Ulcers	Braden
Prevention of Falls and Fall Injuries in the Older Adult	Morse
Assessment and Management of Pain	Old Cart—Campbell

These scales are systematized in the electronic medical record, which establishes the risk according to the score and aids in providing users with multifactorial intervention plans, based on the assessment data. These plans are designed using the recommendations and related evidence for each guideline and are included in the training program for nursing personnel.

## INDICATORS

Analysis of the indicators of each BPG is necessary for selecting the ones to implement in each procedure and an instrumental part of monitoring in each service. The technical data sheets were designed with the purpose of systematically collecting indicator data for each BPG. The indicators selected for the guidelines are shown in Table 15.4.

**TABLE 15.4 INDICATORS SELECTED FOR BPGS**

BPG	SELECTED INDICATORS
Risk Assessment and Prevention of Pressure Ulcers	<ul style="list-style-type: none"> <li>■ Risk assessment</li> <li>■ Risk reassessment</li> <li>■ Intervention</li> <li>■ Classification of pressure ulcers</li> </ul>
Prevention of Falls and Fall Injuries in the Older Adult	<ul style="list-style-type: none"> <li>■ Risk assessment</li> <li>■ Posterior post-fall reassessment</li> <li>■ Multifactorial plan</li> <li>■ Immobilized patients</li> <li>■ Falls rate</li> <li>■ Falls injury</li> </ul>
Assessment and Management of Pain	<ul style="list-style-type: none"> <li>■ Pain detection</li> <li>■ Pain assessment</li> <li>■ Pain management</li> <li>■ Customer satisfaction with pain control</li> </ul>

## IMPLEMENTATION PHASE

An orientation day was designed and delivered to staff of the pilot services and to stakeholders. The BPGs and implementation methodology were also incorporated into the training program for new staff. Within the annual training program, 1 month is assigned to providing updates on guidelines and tips on implementation. For the training of staff and families, educational material is developed to convey the BPG recommendations in a practical way, during the hospital stay and at discharge.

Data collection was initiated at the pilot services, starting with registration in the NQuIRE data system and proceeding to analysis of results and elaboration of quality-improvement plans.

## AUDIT AND MONITORING PHASE

For the audit and monitoring process, BPG rounds were conducted as follows:

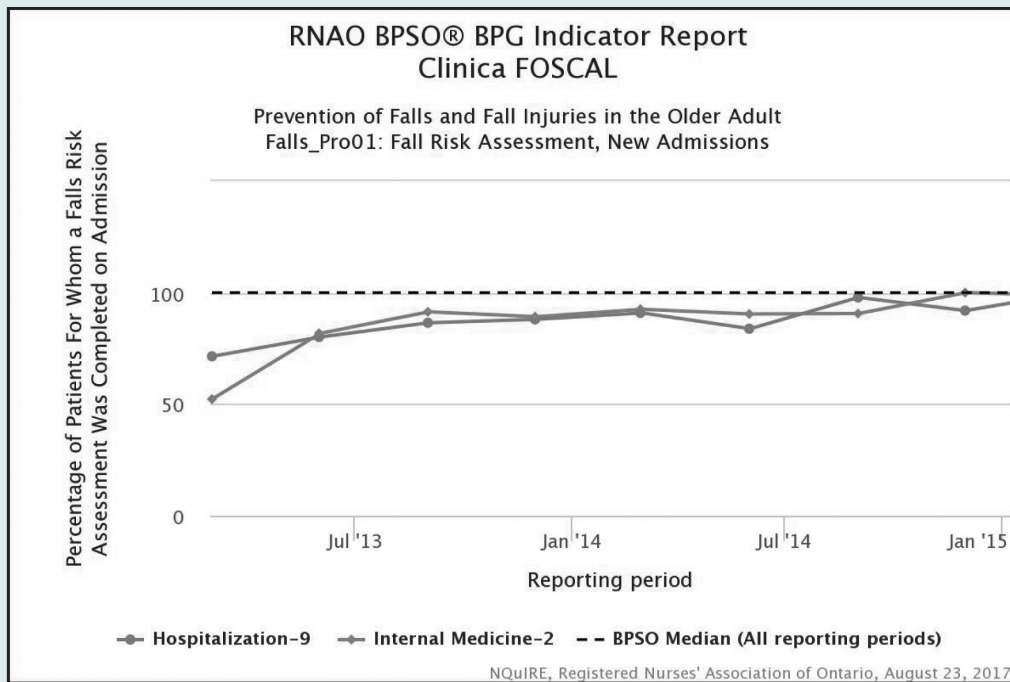
- **Protecting the FOSCAL skin**—The implementation of the selected strategic interventions is evaluated using a checklist that measures staff adherence to BPG recommendations, and the data required for NQuIRE submission are collected.
- **Days without falls**—The institutional billboard of each service shows daily updates with information on days without falls. The service is recognized for this achievement. Families' understanding of the education provided on preventing skin lesions and falls is evaluated using a knowledge questionnaire.
- **Humanization rounds**—These rounds were created to provide staff support and acknowledgement to the services by verifying the assessment and management of pain and reinforcing the adherence of staff to the activities of prevention and identification of pain in patients.

## EVALUATION

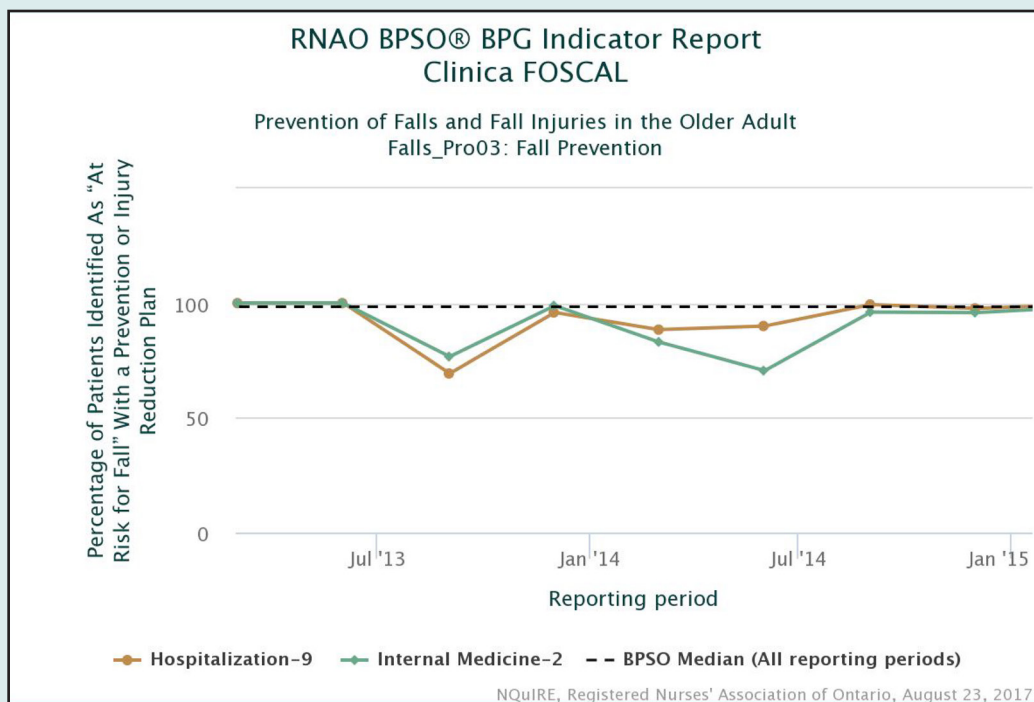
NQuIRE is a database of quality indicators designed for BPSOs to systematically monitor progress and evaluate the results of implementing BPGs. It is the first international quality-improvement initiative of its kind, and involves the development and measurement of structure, process, and outcome indicators related to each BPG. The FOSCAL nursing division performs follow-up every month when reviewing the data on each indicator for the implemented guidelines. For this process, it is necessary

to appoint a general administrator for the organization, and involve the implementation team leaders in collecting data on and monitoring each guideline, analyzing the behaviour for informed decision-making, and correcting any deviations. The most important indicators of each guideline are presented below, reflecting the first 3 years of implementation.

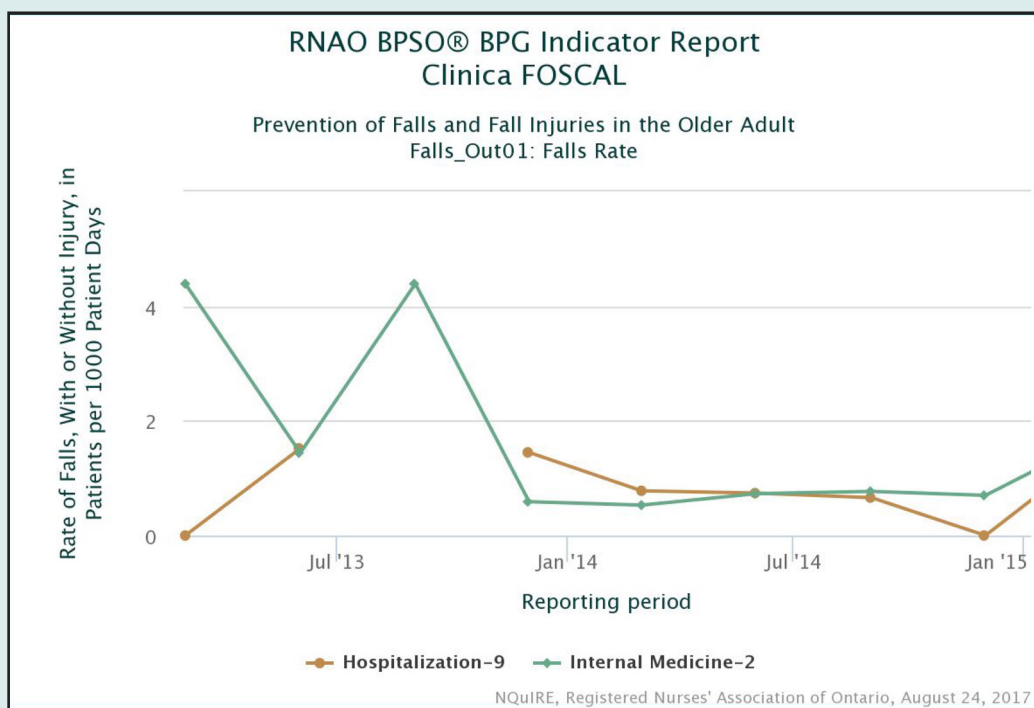
Results on the indicators of *Prevention of Falls and Fall Injuries in the Older Adult* are displayed in Figures 15.5a, 15.5b, and 15.5c.



**FIGURE 15.5A** NQuIRE reporting on fall risk assessment, new admission, FOSCAL. Used with permission.

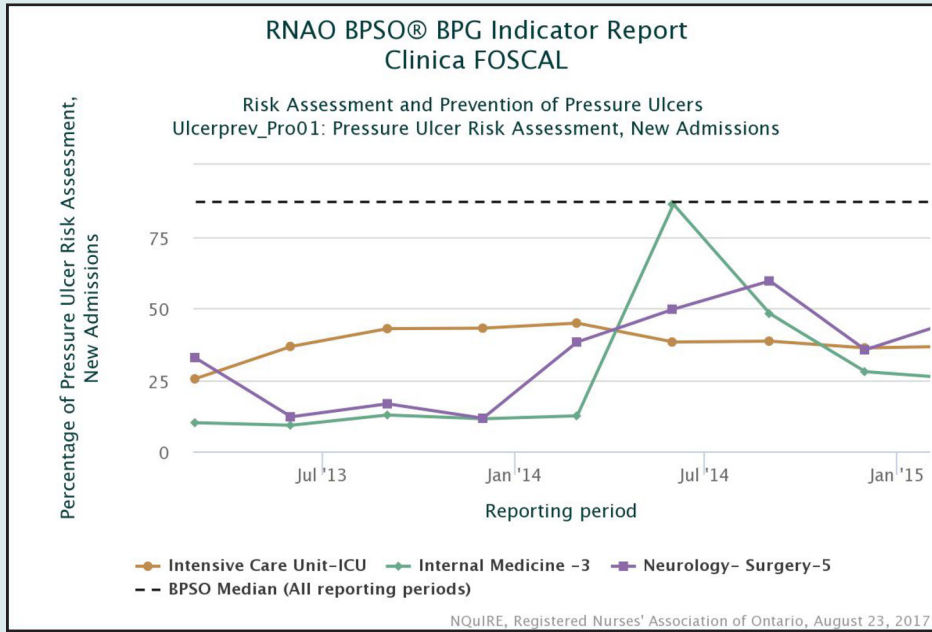


**FIGURE 15.5B** NQuIRE reporting on fall prevention, FOSCAL.  
Used with permission.

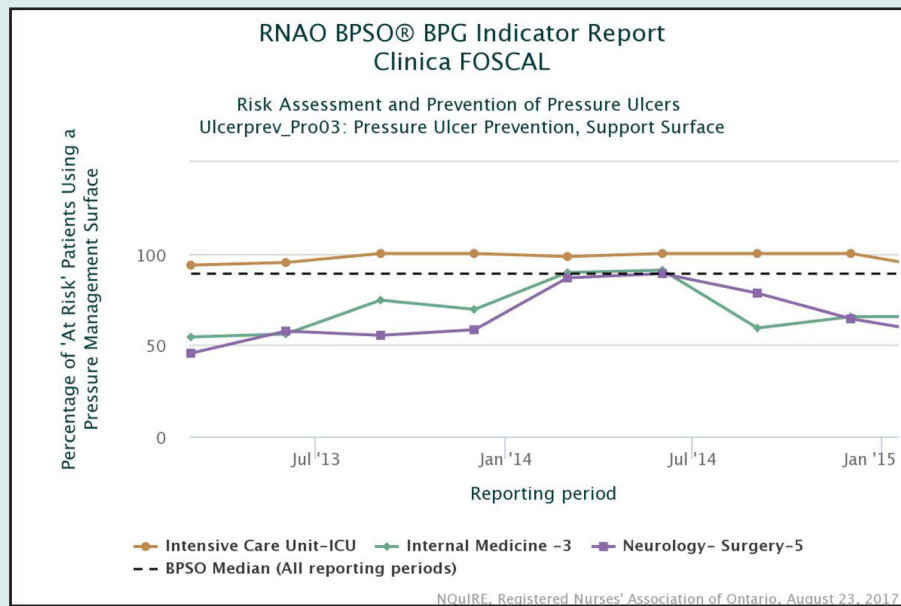


**FIGURE 15.5C** NQuIRE reporting on falls rate, FOSCAL.  
Used with permission.

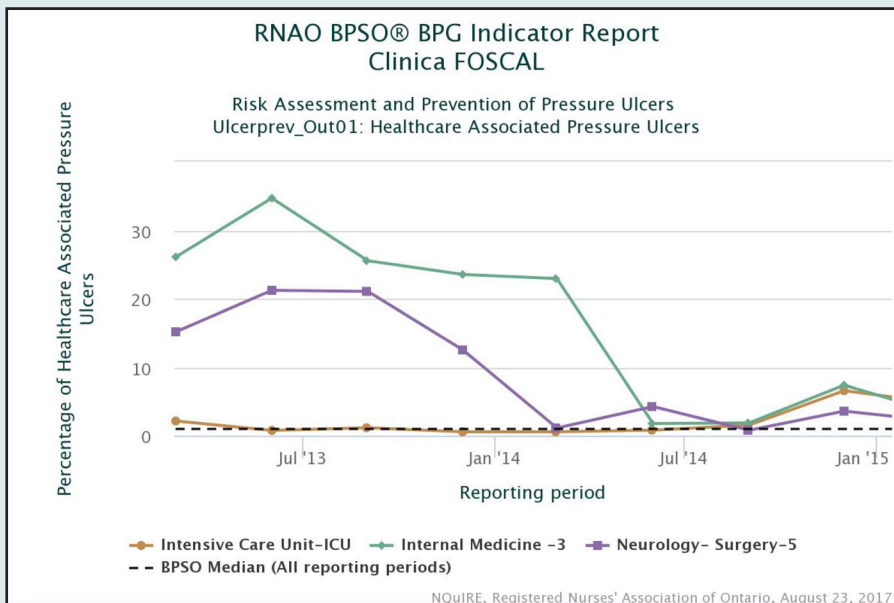
The results on the indicators of *Risk Assessment and Prevention of Pressure Ulcers* are displayed in Figures 15.6a, 15.6b, and 15.6c.



**FIGURE 15.6A** NQIRE reporting on pressure ulcer risk assessment, new admissions, FOSCAL. Used with permission.

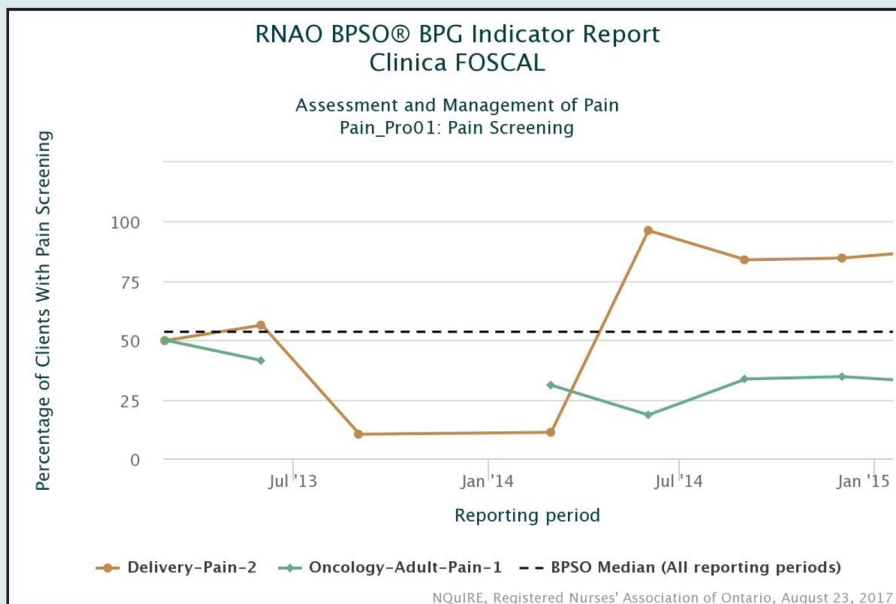


**FIGURE 15.6B** NQIRE reporting on pressure ulcer prevention, FOSCAL. Used with permission.

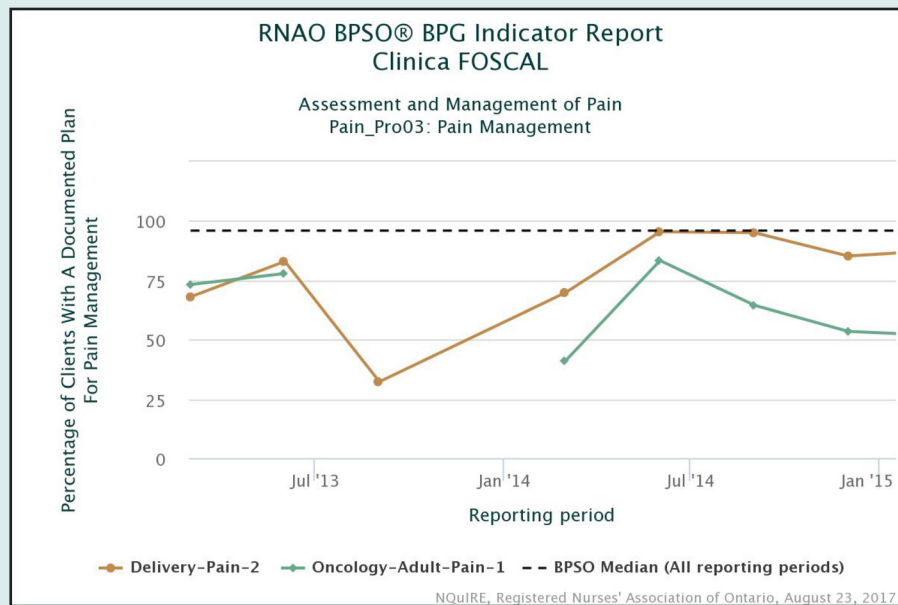


**FIGURE 15.6C** NQIRE reporting on healthcare-associated pressure ulcers, FOSCAL. Used with permission.

Results on the indicators of *Assessment and Management of Pain* are displayed in Figures 15.7a and 15.7b.



**FIGURE 15.7A** NQIRE reporting on pain screening, FOSCAL. Used with permission.



**FIGURE 15.7B** NQuIRE reporting on pain management, FOSCAL.  
Used with permission.

## LEADERSHIP

Nursing leadership is a process that promotes the improvement of health and well-being of the population. It includes the attainment of nursing care objectives and the achievement of goals set for health services. Therefore, it is a process that favours social, professional, and organizational development.

The achievements with the implementation of evidence-based guidelines have been recognized at the institutional, local, and national level, drawing attention to improvements in the care process and elevating the profile of nursing (Grinspun, 2011, 2015). This is the result of several years of work and commitment of all professionals, with the sole purpose of providing quality care to the patient and significantly reducing the indicators that negatively impact on their health and well-being.

The development of knowledge, strengthening of professional decision-making, standardization, and resolution of issues in nursing practice culminate in improved care and health outcomes. Based on its results in preventing falls and fall injuries in older adults, the institution has been identified as a leader in best practices and as an exemplar in decreasing the incidence of falls using evidence-based interventions and monitoring outcomes.

FOSCAL's leadership serves as a reference for the Ministry of Health and Social Protection in strengthening the process in different institutions around the country.

## OUTCOMES AND ACHIEVEMENTS

FOSCAL successfully attained its BPSO Designation in April 2015, at the RNAO Designation ceremony in Toronto, Canada (RNAO, 2015). Prior to that, in 2014, FOSCAL participated in the IV International Congress of Nursing, hosted by fellow BPSO Hospital Cardio-Infantil (FCI-IC) in Bogotá, Colombia. There, FOSCAL presented two posters and participated in a forum on the experience of implementing evidence-based guidelines. Furthermore, FOSCAL's accomplishments as part of the BPSO Program have been recognized through:

- An invitation to participate in the XIV Pan-American Nursing Research Colloquium
- Being featured in a video by the Ministry of Health and Social Protection as an exemplary institution at the national level, in best practices
- Earning second place in the Oral Mode of the Leadership Prize in Prevention of Skin Damage

- Presentation at the National Nursing Days of Alicante, Spain, on FOSCAL's experience with local success and international leadership related to implementing RNAO's clinical guidelines
- Publication of an article in the *MedUNAB* journal titled "Implementation of Best Practice Guidelines: Experience at the Ophthalmological Foundation of Santander (FOSCAL)" (Esparza-Bohórquez et al., 2016)

## CONCLUSION

As a group of nurses at FOSCAL, we have become leaders in Colombia in the implementation of evidence-based guidelines, and we demonstrate a tangible impact on the outcomes and quality of care, which we provide to patients with a high level of warmth. Evidence-based

knowledge has enabled FOSCAL to exercise nursing leadership in achieving change and motivating other organizations to participate in this important process—this is the best part of our experience. Our gains are further reflected in the decrease of adverse events; increase in the satisfaction of patients and work teams during the care process; updating of care processes; participation in academic events, and national and international publications; and sharing their experiences in the process of transferring knowledge to practice and advancing nursing.



## REFLECTION

*What were the key drivers in the success of the BPSO Designation in FOSCAL? What key barriers were overcome and how?*

## C A S E S T U D Y

# THE EXPERIENCE OF CLÍNICA LAS CONDES IN IMPLEMENTING RNAO EVIDENCE-BASED GUIDELINES

Clinical practice in current health systems is undergoing an important paradigm shift. Since the 1980s, the Evidence-Based Medicine (EBM) movement has endorsed the need to have trained professionals at the forefront of knowledge, so that we can ensure safe, quality care for our patients. It is widely accepted that professional practice based on evidence or results from research and its use contributes to improving the health of the population. However, according to some studies published in this regard, at least 40% of patients do not receive care consistent with the results of the research and, consequently, between 20% and 25% of care may be unnecessary and even potentially harmful (Grinspun, Melnyk, & Fineout-Overholt, 2010; Moreno-Casbas, Fuentelsaz-Gallego, Gonza, Rey, & Carlos, 2016).

In addition to this, there are several barriers to research use in nursing: lack of time, lack of motivation, lack of support from management, structures of organizations, lack of support from coworkers, lack of funding, scarce staffing, and insufficient methodological knowledge

(Moreno-Casbas et al., 2016). These factors result in low interest in and adherence to evidence-based work—a reality that Clínica las Condes faced and grappled with.

It is in this context that, at the beginning of 2010, the nursing management at Clínica las Condes (CLC) wanted to expand its field of action and decided to partner with the Registered Nurses' Association of Ontario (RNAO) through its international BPSO Designation, which not only allowed the institution to learn the best practices in nursing care based on scientific evidence, but also enabled its implementation, evaluation, and subsequent maintenance. This has undoubtedly become an incentive for nursing staff, who strive daily to provide quality, safe, and efficient care to their patients based on the best scientific advice available.

Today, CLC's collaborators have a sustainable and firm theoretical framework that allows them to shape the decisions they make with their patients with the support of evidence-based documents (clinical guidelines and

recommendations) prepared by the RNAO BPG Program. This in turn empowers the nursing role and positions nurses solidly as knowledge professionals providing quality care in our institution. The purpose of this case study is to describe the experience of CLC in the implementation of clinical practice guidelines in nursing.

## THE BEGINNING

In 2010, the nursing management at CLC initiated the first steps of their BPSO journey, which began with outreach by the chief nurse at the time to RNAO and their beginning conversations about the BPSO partnership. Once this was set in motion, CLC formed working groups that were led by the chief nurses of each clinical unit. They discussed the scope of the program and identified the BPGs for implementation: *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b) and *Assessment and Management of Stage I to IV Pressure Ulcers* (RNAO, 2007a).

Despite the striking initiative and keenness shown by the heads of nursing, they were met with challenges to internalize the BPSO Designation and comply with all of the deliverables requested by RNAO. CLC's nurses went ahead and added the two above BPGs to their already scheduled work, without necessarily being trained or prepared for other aspects of the program. The situation was compounded by changes in nursing leadership during the period between 2010 and 2012. Thus, in order to stabilize the conditions for the BPSO Designation, the BPSO Lead was appointed and responsible for facilitating the program, raising awareness, and motivating nurses and other health professionals to participate and collaborate. Working groups were also solidified in a way that each member assumed a function of supporting implementation of a particular guideline (see Figure 15.8).



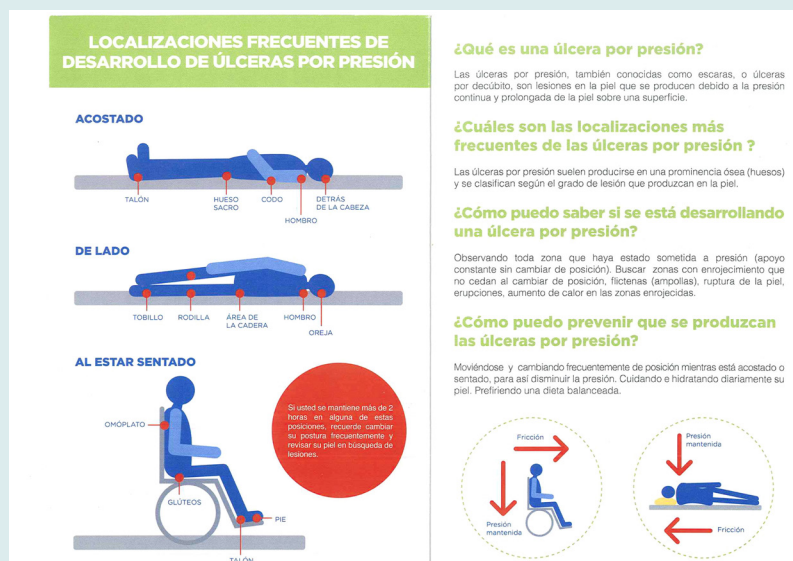
**FIGURE 15.8** BPSO team structure at CLC, 2017.

These working groups are primarily composed of a nurse educator, palliative care nurse, wound nurse, ostomy nurse, quality nurse in surgical pavilions and project nurse, and teaching and research nurses. They began work in 2013 on implementing the *Risk Assessment and Prevention of Pressure Ulcers BPG* (RNAO, 2011b) and adapting the institutional policy according to the BPG's

recommendations. This work was complemented by the development of two specific institutional policies: one for hospitalized patients and the second for patients treated in surgical rooms. At the same time, there was work on developing BPSO badges and educational brochures for patients and families, which promoted BPG dissemination (see Figures 15.9a and 15.9b).



**FIGURE 15.9A** BPSO badge developed by Clínica las Condes. Used with permission.



**FIGURE 15.9B** BPSO educational brochure developed by Clínica las Condes. Used with permission.

As the program's infrastructure and activity became established and functional, it gradually earned recognition by the heads of nursing in each clinical unit.

By the end of 2013, the team began the creation of eLearning training for the prevention of pressure ulcers, based on the RNAO BPG, aimed at nurses and nursing technicians. The goal was to facilitate improved uptake of knowledge through distance learning, leading to improved clinical outcomes. More details on the eLearning program will be shared later in this case study.

With time, the BPSO Program gained stability and took shape. One of the key actions was to set the ideal composition of the working group, which should include nurses in the areas of quality of care, wound care, pain management, and project management. As a whole, this would ensure that a specific guideline is fully implemented, along with capacity-building and other related objectives. Figure 15.8 summarizes the organization of the team for the year 2017 and demonstrates the BPSO leadership and the BPG Leader and Champion team for each BPG being implemented.

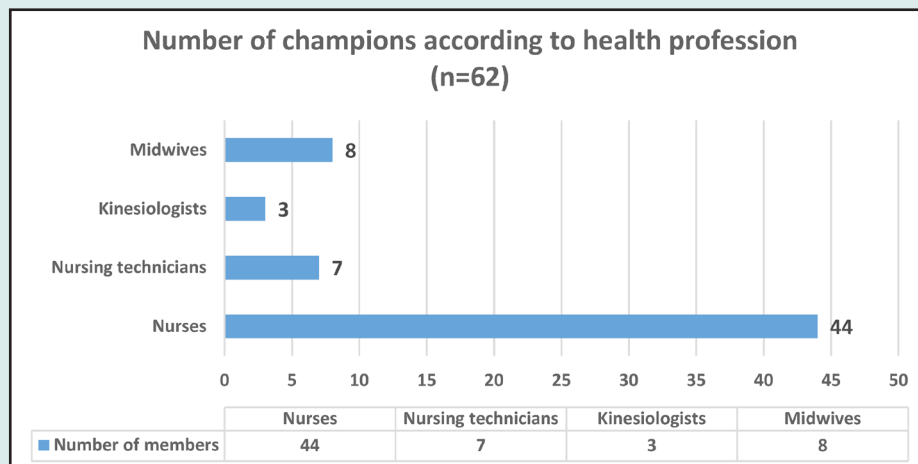
## CHAMPIONS

The development of BPG Champions began in 2011 with the adoption of the guideline on *Risk Assessment and Prevention of Pressure Ulcers* (RNAO, 2011b). From the outset, participation in the BPSO Program was entirely voluntary, which fosters greater commitment and

endurance of the participants. Today, CLC counts amongst its staff a total of 64 Champions for the different BPGs implemented (see Figure 15.10). The Champions' main functions include the following:

- Carefully review clinical guidelines for their work group
- Actively review action guides and protocols of Clínica las Condes that correspond to the guideline of their RNAO working group
- Motivate colleagues to follow nursing best practices within their clinical services
- Present on the BPG recommendations and results on a semi-annual basis through participatory meetings in their respective clinical services
- Present on the results and themes to the RNAO group on an annual basis
- Ensure compliance with the guidelines implemented in each clinical service

It is also important to note that, although the program started by recruiting only nurses as Champions, there are already other health professionals who have joined the BPG implementation process on a continuous basis, as detailed in Figure 15.10. The chart provides a more global and interdisciplinary view of the Champions program at CLC.



**FIGURE 15.10** Number of Champions by profession, CLC.  
Used with permission.

This is how, almost 6 years after the start of Champions training, some of them have referred to the program through the following testimonials:

*“Being part of the BPG Champion Network has been very gratifying, since you can contribute to the overall approach to nursing care and give quality care to patients. Being a member of a group of nurses and other health professionals who belong to different services, I got to know other realities that we face day to day. Thus together across disciplines and services, we seek the best way to solve problems with best evidence. We all work for the same purpose, giving better care to our patients.”*

–Paulina Sanhueza, Nurse, Surgical Services

*“I volunteered to be a Champion almost a year ago. It has been a time full of challenges, a lot of dedication and teamwork. Seeing how the BPSO has emerged has been super rewarding for me on a personal and professional level. In internalizing the existence of the RNAO BPGs, I realized that it not only provides us with an evidence-based framework for our professional work, but also helps us to generate more evidence. In relation to CLC, our strong commitment to evidence-based practice and our results have given us an international profile of excellence in care.”*

–Barbara Silva, Nurse, Paediatric Services

*“It has been interesting because working with people from other disciplines is good. As a kinesiologist, being in the fall prevention group has contributed positively to my work and has been very enriching for me. I am now much more aware of falls and fall prevention, and we have taken precautions to strengthen patient safety.”*

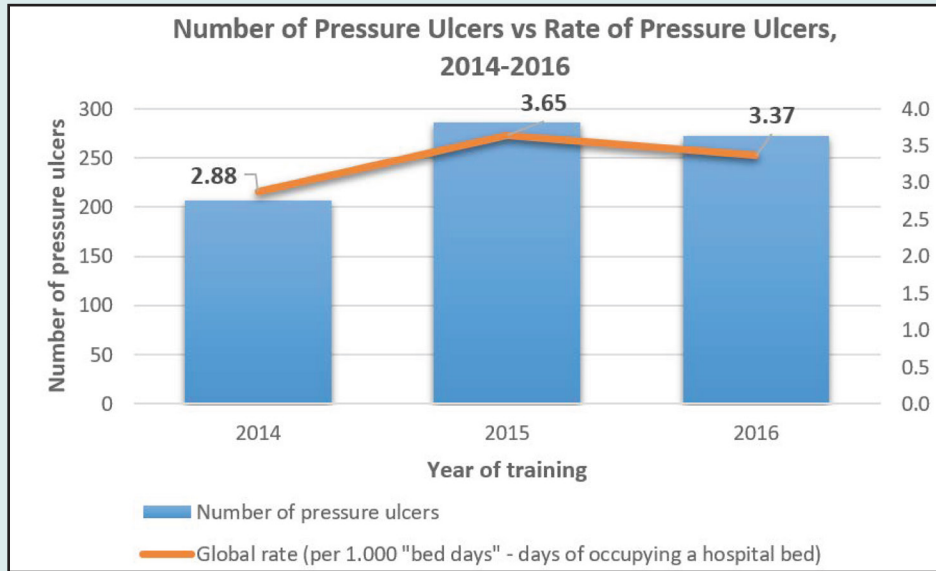
–Giancarlo Calcagno, Kinesiology

## MILESTONES

One of the most important milestones in the implementation of RNAO’s Best Practice Guidelines took place in 2014, with the launch of eLearning training for the prevention of pressure ulcers. This educational program was born from the need to maintain nursing skills without demanding the time of collaborators to attend in-person classes. Furthermore, the use of information and communication technologies made it possible to facilitate knowledge transfer on a much more efficient level compared to traditional face-to-face methodology. In this way, a total of approximately 941 nurses and nursing technicians were trained through eLearning technology (see Figure 15.11).

Since 2005, CLC has adopted this system of learning, which its staff has rated as excellent, given the possibility to complete training from home or another location, based on their schedule. On top of this, further advantages of distance learning have been identified as follows (Villaverde, 2013):

- Exceeds the limits of the classroom
- Adapts to the pace of the individual learner
- Allows flexible use of time
- Employs a variety of means and resources
- Does not detach people from their work or family environment
- Promotes the autonomy of the participants



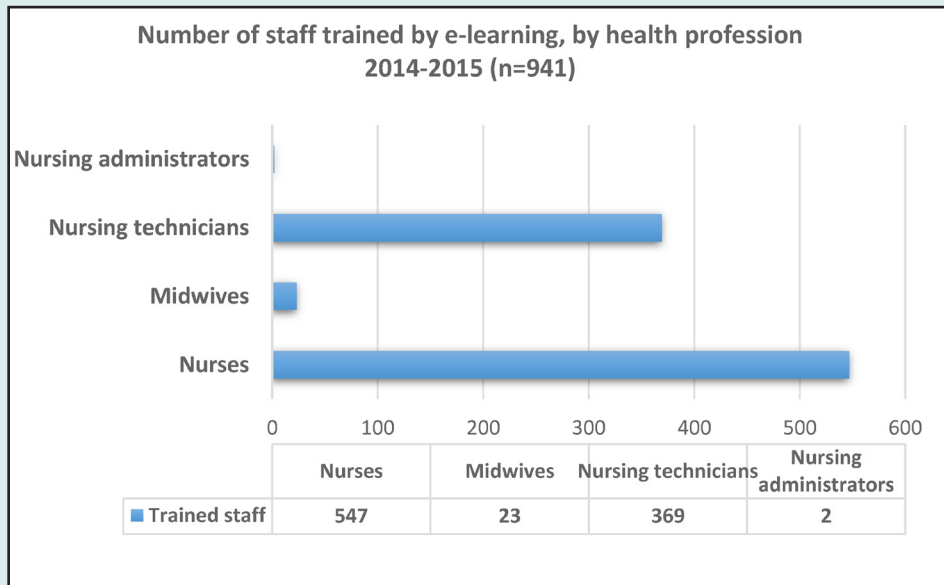
**FIGURE 15.11** Number of staff trained by eLearning, CLC. Used with permission.

The benefits of using educational software in teaching and learning are as follows (Barrios Araya, Masalán Apip, & Cook, 2011):

- It is a medium that offers students information visually through the laptop or computer.
- It has a great capacity for motivating students.
- Communication can be bidirectional, establishing continuous feedback with the student.
- The work can be adapted to the work and style of learning of each student individually, which corroborates the principle of individualization advocated by the new education system.

- Correction and evaluation of exercises can be immediate if there is interactivity.
- It is a means capable of showing and simulating reality almost perfectly.

The value of this learning methodology in building the knowledge base of nurses in relation to wound prevention and care was reflected in the patient wound outcome data. CLC opened its new hospital building in 2014, with double its previous bed capacity and almost double the number of existing staff. In spite of these factors, the rate of pressure ulcers reported at the institutional level did not suffer great variations (see Figure 15.12). On the contrary, the rate decreased in 2015, a fact that affirms the effectiveness of evidence-based care and its diffusion through eLearning methodology.



**FIGURE 15.12** Number of pressure ulcers in CLC vs. global rate of pressure ulcers, 2014-2016, CLC.  
Used with permission.

CLC has been an innovator and become a leader amongst the country's hospitals through engagement in the BPSO Designation and promoting staff learning and their adherence to BPG implementation.

## PROGRESS AND RESULTS TO DATE

At present, RNAO's BPGs and their implementation have become indispensable to the care of our patients. Following the implementation of evidence-based guidelines, four institutional protocols have been modified to date in all areas of CLC, which were approved by the Nursing Manager and Medical Director. These mandate the compliance of all health professionals involved in patient care. In addition, the search for the best scientific evidence to integrate in care has been included in the plans for continuous improvement of clinical units, in all institutional training, and in all orientation processes for nurses and nursing technicians. This is slowly generating a cultural change that, on top of providing knowledge, empowers clinical staff to make the best-informed decisions in the care of their patients.

The formation of BPG Champions has been fundamental to the BPSO success at CLC. Their commitment is reflected in the low turnover (2 people out of 66), which can be linked to their voluntary application to the program and their high degree of participation in the improvement measures proposed for the detected issues. Furthermore, being prepared to lead a theme and guide their colleagues toward continuous improvement based on best practices induces a greater motivation in the Champions to always be up-to-date in knowledge and to transmit it in a timely manner. Peer recognition fuels the further success of Champions, as there is better receptiveness, and in turn learning, that takes place amongst peers.

Another factor that has contributed to the motivation of Champions is the recognition and continuous positive reinforcement by the CLC Chief Nurse, the nursing managers, and BPSO team at CLC. Activities such as the certification of Champions, held in December 2016 with RNAO CEO Dr. Doris Grinspun, acknowledge teamwork and commitment, as well as encourage staff to play a greater role in clinical practice. Through this they are empowered and motivated to provide optimal care to patients.

## NEXT STEPS

CLC is currently working on the implementation of two new guidelines: the BPG for the *Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes* (RNAO, 2009) and *Integrating Smoking Cessation into Daily Nursing Practice* (RNAO, 2007b). These guidelines have been revised with the purpose of being implemented in centers for prevention and treatment of these pathologies, which extends CLC's services to ambulatory patients and their families. At the same time, both centers (diabetes center and cancer clinical center) are drafting the institutional policy, based on the RNAO BPG recommendations, to ensure full and sustained adoption following its launch. The full process is expected to take place at the end of 2017.

The BPSO team is also working on new strategies to motivate existing Champions to take on new challenges, offering them greater visibility and accountability to their colleagues. A clear example of this is Champions' participation in the recording of the new version of the eLearning on prevention of pressure ulcers. Also part of the portfolio of upcoming projects is the development of vascular care access equipment in accordance with the RNAO BPG *Assessment and Device Selection for Vascular Access* (RNAO, 2008), massive campaigns for prevention for falls, and beginning of supervision of the implementation of *Assessment and Management of Pain* BPG (RNAO, 2013b). For the latter, CLC Champions,

supported by members of the BPSO team, will supervise compliance with the BPG recommendations and guide their colleagues toward the correct filling of pain rating scales.

Finally, Clínica las Condes is promoting programs to recognize Champions. The objective is to highlight the involvement of participants in the BPSO Designation, to maintain their motivation, and to empower them and help them empower their colleagues as knowledge professionals. Through this, their positive performance is acknowledged and reinforced, which in turn will motivate more health professionals to join the BPSO journey.

## CONCLUSION

The implementation of clinical practice guidelines allows us to have clear guidance for changes and improvements that must be made in our daily actions, in favour of the standardization of care based on evidence and the reduction of clinical variability.

The use of innovative strategies, empowerment of professionals, and ongoing motivation methods have enabled us to maintain and scale out BPG implementation to more areas of the institution, as well as to more health professionals. The Nursing Manager of CLC, Mrs. Sonia Abad Vasquez, also emphasizes the spread of evidence-based practice at every opportunity, such as during her address at the 2017 Nursing Day:

*“Managing care in a timely, safe, and satisfactory manner implies responding to our patients with the best evidence available to make the best decisions about caring for people. Evidence-based nursing is thus emerging as a valid instrument to sustain nursing practice and improve quality of care.”*

Adding to this is her opinion on the next challenges for CLC in that direction:

*“The challenge of nursing at Clínica las Condes is to continue in this way, strengthening our profession based on knowledge and contributing to the health team in such a way to achieve the best results for our patients.”*

Undoubtedly, Clínica las Condes has changed its paradigm of patient care over the last several years. Today, quality and safety of care are basic pillars guiding our standards, and it is within this framework that evidence-based nursing, embracing RNAO's Best Practice Guidelines, plays a fundamental role in fulfilling these pillars. In addition, the development of Champions has allowed us to bring out the best in our collaborators and enable and empower them to participate in the improvement plans for better care.

Finally, one of the greatest challenges for a health organization is to not only maintain, but to advance

methodological rigor in our implementation, measurement of results, and creation of improvement plans in each area. We continue to strive for this, as well as motivating health professionals to use the best evidence available with patients, thereby always ensuring that we improve our quality of service.




---

*What were the key drivers in the success of the BPSO Designation in CLC? What key barriers were overcome and how?*

---

## THE LATIN AMERICA BPSO CONSORTIUM: FROM STRENGTH TO GREATER STRENGTH

Much has been said about RNAO's BPSO Designation, its comprehensiveness and overall success (Grinspun, 2015, 2017). The Latin America BPSO Consortium is a lived example of the BPSO Designation's success in the Latin American context. The BPSOs in the consortium derive tremendous strength individually and as a group. Together they have developed a unique bond and strong collective identity, which is continuously expressed in their visual symbols, as well as their mutual support and desire to work as partners. This cognitive, social, and emotional sharing of knowledge and experiences, successes, and failures has served them well in advancing BPG uptake and sustainability, as well as BPSO Program fidelity. It has also become a source of strength and inspiration for new BPSOs in the region and elsewhere.

In 2014, the *Programa de Enfermería at Universidad Autónoma de Bucaramanga (UNAB)*, in Bucaramanga, Colombia, joined as a BPSO Direct-Academia. In 2017, the consortium gained three new BPSO Hosts—two of these in Chile and one in Peru—which together bring 20 new service and academic organizations. Evolving from a modest consortium of 4 hospitals and 1 university in 2012 to a sizable 25 organizations in 2017, the Latin America BPSO Consortium has moved to be the third largest partner in the RNAO BPSO Program following Canada and Spain. What's more important is the nature of the three BPSO Hosts that have recently joined and the capacity they have to catapult the Latin America BPSO Consortium to new heights of collaboration, achievements, and the furthering of the RNAO BPSO Program's collective identity flavoured by its unique cultural context.

The first BPSO Host is Universidad de Chile, which applied and was approved to move from being a BPSO Direct to a BPSO Host and will take five Chilean universities as its direct academic BPSOs. The second BPSO Host is the Ministerio de Salud de Chile, known as MINSAL, where the agreement was signed in a formal televised ceremony by their national Minister of Health and RNAO'S CEO, marking the highest level international agreement signed to the program. The MINSAL agreement began with seven BPSO Direct-Service hospitals in various Chilean regions and will quickly expand to additional public hospitals and primary care organizations in that country (El America, 2017; RNAO, 2017). The third BPSO Host, the Colegio de Enfermeros del Peru, began its journey leading with six BPSO Direct-Service hospitals and two BPSO Direct-Academia universities (The Trujillo Com, 2017; Panamericana TV, 2017; RNAO, 2017).

From the onset, all these BPSOs gained tremendous support from the consortium founding members and the robust infrastructure that RNAO has in place. The Orientation Program for each of these new BPSOs was co-led by RNAO's CEO and one of the founding regional BPSO leaders, knowing that the newcomers would benefit from RNAO's expertise and also the experience and local knowledge context of an existing academic and/or service BPSO leader in the region.

All new BPSOs have joined the regular knowledge-exchange bimonthly meetings, where they learn from the strategies and successes of other BPSOs and receive mentoring for any challenges encountered. For example, UNAB was introduced to the innovative eTraining modules developed by Clínica las Condes, which through its in-kind obligations with RNAO provides access to these and other resources it created as part of its solid educational repository. All the new BPSO leads have benefited from attending the BPSO annual regional conference, which rotates between countries. In addition, some have joined a working group of academic BPSOs that is developing NQuIRE indicators particular to the integration of BPGs into curricula.

## REFLECTION

*Compare and contrast the BPSOs from perspectives of success factors, approaches to engagement, management of barriers, a unique focus, and results.*

## CONCLUSION

The Latin America BPSO Consortium is a success story at many levels. First, the partners' incredible enthusiasm, unwavering commitment, and extraordinary leadership is inspiring to all and an exemplar to the RNAO BPSO Designation overall, fuelling success, sustainability, and fidelity. Second, their capacity to share, support, and propel one another within and between countries is limitless. This rich exchange takes place on a continuous basis both formally through the consortium's meetings with RNAO and informally amongst themselves via emails, phone calls, and onsite visits. Thirdly, this consortium lives in their narratives and in their actions the collective identity that characterizes the social movement of educational and clinical practice changes that the BPSO Designation has created. Fourth and last, it was the Latin America Consortium that propelled RNAO to create its train the trainer models. With its rapid expansion in a region that uses Spanish, it was imperative for RNAO to create solutions that are both responsive and cost effective.

The Latin America Consortium was amongst the first to experience the benefits of RNAO's capacity building programs of Certified BPSO Orientation Trainers and Auditors. These programs are detailed in Chapter 12, *RNAO's Global Spread of BPGs: The BPSO Designation Sustainability and Fidelity*. Their use with the Latin America BPSO Consortium at UNAB, MINSAL and its 7 BPSO Directs, as well as the Colegio de Enfermeros del Peru and its 7 BPSO Directs, exemplifies RNAO's maturity and ability to continuously innovate its BPG Program infrastructure and BPSO delivery models. By building capacity in its established processes for training and onsite audits, RNAO enables continued growth and sustainability of a widespread BPSO Designation. In the case of Latin America, this is proving to be beneficial because the certification of BPSO Leads as trainers and auditors in the region is resulting in less travel, cost-effectiveness for BPSOs, greater ease of communication, and recognition of regional expertise.

## KEY MESSAGES

- The BPSO Designation is adaptable to different contexts with outstanding results.
- Energized leadership locally and regionally is critical in spreading the BPSO Designation across different cultures and contexts.
- Organizational and staff readiness in conjunction with a clear, meaningful, and comprehensive organizational-level BPG implementation strategy, such as the BPSO Designation, can lead to a sustained cultural shift.
- Key BPSO deliverables related to creating an infrastructure, capacity building, comprehensive implementation plans, attention to evaluation, dissemination of results, and adherence to RNAO monitoring requirements all impact success as a BPSO.
- Peer support amongst BPSOs is a strong lever in successful uptake of BPGs and their sustained use.
- RNAO's NQuIRE is a robust tool to position the impact of excellence in nursing practice in organizations.
- BPSOs have proven to be a powerful mechanism to sustain and spread the use of RNAO's BPGs, as well as maintain the Program's fidelity.
- The BPSO Training of Trainers Model has contributed to rapid expansion of BPSOs in the Latin American region, impacting costs, communication, development, and recognition of local and regional leaders.
- The Latin America BPSO Consortium showcases a strong collective identity developed over time through common experiences and emotional investment, which fosters sustained BPG use in practice and education, resulting in positive outcomes for patients and organizations.

## REFERENCES

- Barrios Araya, S., Masalán Apip, M. zP., & Cook, M. P. (2011). Health education: In search of innovative methodologies. *Science and Nursing*, 17(1), 57–69. <https://dx.doi.org/10.4067/S0717-95532011000100007>
- Dearholt, S., & Dang, D. (2012). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (2nd ed.). Indianapolis, IN: Sigma Theta Tau International.
- DiCenso, A., Virani, T., Bajnok, I., Borycki, E., Davies, B., Graham, I., . . . Scott, J. (2002). A toolkit to facilitate the implementation of clinical practice guidelines in healthcare settings. *Hospital Quarterly*, 5(3), 55–60.
- El América. (2017). <http://elamerica.cl/2017/12/13/chile-y-canada-celebran-convenio-de-acuerdo-para-la-implementacion-de-guias-de-practica-clinica-basadas-en-evidencia/> Diciembre 13, 2017
- Esparza-Bohórquez, M., Granados Oliveros, L. M., & Joya-Guevara, K. (2016). Implementación de la guía de buenas prácticas: Valoración del riesgo y prevención de úlceras por presión: Experiencia en la Fundación Oftalmológica de Santander (FOSCAL). *MedUNAB*, 19(2), 115–123.
- Fundación Cardio-Infantil IC. (2012, October 17). *Informe anual de gestión. Fundación Cardio-Infantil IC. Bogotá, 2009–2012*. [PowerPoint slides]. Retrieved from <http://www.slideshare.net/pasante/1caso-de-xito-fundacin-cardioinfantil-turismo-de-salud>
- Grinspun, D. (2007). Healthy workplaces: The case for shared clinical decision making and increased full-Time employment. *Healthcare Papers* (Special Issue), 7, 69–75.
- Grinspun, D. (2011). Guías de práctica clínica y entorno laboral basados en la evidencia elaboradas por la Registered Nurses' Association of Ontario (RNAO). *Enfermería Clínica*, 21(1), 1–2.
- Grinspun, D. (2015). Transforming nursing practice through evidence. *Revista MedUNAB*, 17(3), 133–134.

- Grinspun, D. (2017). Leading evidence-based nursing care through systematized processes (Editorial). *Revista MedUNAB*, 19(2), 83–84. Retrieved from <http://revistas.unab.edu.co/index.php?journal=medunab&page=article&op=view&path%5B%5D=2615>
- Grinspun, D., & Aninyam, C. (2014). Leadership. In S. Coffey & C. Anyinam (Eds.), *Interprofessional health care practice* (1st ed.), (131–158). Toronto, Canada: Pearson Canada Inc.
- Grinspun, D., Melnyk, B. M., & Fineout-Overholt, E. (2014). Advancing optimal care with rigorously developed clinical practice guidelines and evidence-based recommendations. In B. M. Melnyk & E. Fineout-Overholt (Eds.), *Evidence-based practice in nursing & healthcare. A guide to best practice* (3rd ed.), (182–201). Philadelphia, PA: Lippincott, Williams & Wilkins.
- Haines, S. (2005). *Leading strategic change*. San Diego, CA: Systems Thinking Press.
- Lucía Cortés, O., Serna-Restrepo, A., Salazar-Beltrán, L. D., Rojas-Castañeda, Y. A., Cabrera-González, S., & Arévalo-Sandoval, I. (2016). Implementación de guías de práctica clínica de la Asociación de Enfermeras de Ontario-RNAO: Una experiencia de enfermería en un hospital colombiano. *MedUNAB*, 19(2), 103–114.
- Moreno-Casbas, T., Fuentelsaz-Gallego, C., González-María, E., & Gil de Miguel, A. (2010 May-June). Barreras para la utilización de la investigación. Estudio descriptivo en profesionales de enfermería de la práctica clínica y en investigadores activos. *Enfermería Clínica*. 20(3), 153–164. doi.org/10.1016/j.enfcli.2010.01.005
- Panamericana TV. (2017). <https://panamericana.pe/24horas/salud/237180-enfermeros-peru-canada-firman-importante-acuerdo-internacional>
- Registered Nurses' Association of Ontario (RNAO). (2007a). *Assessment and management of stage I to IV pressure ulcers*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2007b). *Integrating smoking cessation into daily nursing practice*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2008). *Assessment and device selection for vascular access*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2009). *Best Practice Guideline for the subcutaneous administration of insulin in adults with type 2 diabetes*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2011a). *Prevention of falls and fall injuries in the older adult*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2011b). *Risk assessment and prevention of pressure ulcers*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2012a, July 9). *RNAO's clinical Best Practice Guidelines debut in Chile and Colombia*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2012b). *Toolkit: Implementation of Best Practice Guidelines* (2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2013a). *Assessment and management of foot ulcers for people with diabetes* (2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2013b). *Assessment and management of pain*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2013c). *Developing and sustaining nursing leadership*. Toronto, ON: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2015, April 9). *RNAO celebrates milestone anniversary with international flare*. Retrieved from <http://rnao.ca/news/media-releases/2015/04/09/rnao-celebrates-milestone-anniversary-international-flare>
- Scottish Intercollegiate Guidelines Network (SIGN). (2008). *SIGN 50: A guideline developer's handbook*. Retrieved from <http://www.sign.ac.uk/guidelines/fulltext/50/>
- The Trujillo Com. (Enero 4, 2018). <https://detrujillo.com/colegio-de-enfermeros-del-peru-firma-convenio-con-canada-para-implementar-modelo-de-buenas-practicas-clinicas/>
- Villaverde, M. F. (2013). Distance education and its relation with the new technologies of the information and the communications. *MediSur*, 11(3), 280–295. Retrieved from [http://scielo.sld.cu/scielo.php?script=sci\\_arttext&pid=S1727-897X2013000300006&lng=en&tlng=en](http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S1727-897X2013000300006&lng=en&tlng=en)