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

CHAPTER

7

THE BPSO PIONEERS: CREATING, SUSTAINING, AND EXPANDING EVIDENCE-BASED CULTURES THROUGH THE BPSO DESIGNATION

Shirlee M. Sharkey, CHE, MHSc, BScN, BA
Nancy Lefebre, FCCHL, Extra Fellow, CHE, MScN, BScN
Karen L. Ray, MSc, RN
Anne-Marie Malek, CHE, MHSA, BN, RN
Barbara Bell, CHE, MN, BScN, RN
Ru Taggar, MN, RN
Beth O'Leary, PMP
Tracey DasGupta, MN, RN

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe roles of innovators and early adopters in implementation of Best Practice Guidelines (BPG) and creation of evidence-based practice cultures
- Identify how to utilize successes and challenges in implementing large-scale change
- Outline strategies for sustainment of BPGs
- Understand the contribution of leadership at the executive level in creating an evidence-based practice culture
- Determine lessons learned through the Best Practice Spotlight Organization (BPSO) Designation experience

INTRODUCTION

Quality patient, provider, and organizational outcomes are the primary aim of today's healthcare system (Canadian Institute of Health Information [CIHI], 2013). Care must be based on current evidence to ensure results are achieved in the best and most effective way possible (DiCenso, 2003). This has led to the original mandate of the Registered Nurses' Association of Ontario (RNAO): to create clinical Best Practice Guidelines and embrace implementation science processes to change practice (Grinspun, Virani, & Bajnok, 2002). This chapter describes the experience of three organizations, from different healthcare sectors in Ontario, that each achieved the RNAO Best Practice Spotlight Organization (BPSO) Designation. They are: 1) Saint Elizabeth, a home healthcare organization; 2) West Park Healthcare Centre, a rehabilitative care organization; and 3) Sunnybrook Health Sciences Centre, an acute care organization. In sharing our journeys, we outline the decision to engage in evidence-based practice (EBP); our successes and challenges in implementing Best Practice Guidelines (BPG) over an 18-year period; sustainability strategies; and finally, how each organization will take its BPSO work into the future.

The profound link between nursing work environments and healthy outcomes is one that all three organizations were quick to discover (Duffield et al., 2011; Purdy et al., 2010). The culture of an organization needs to be safe and supportive, leading to effective recruitment and retention as well as job satisfaction. In the beginning, early adopter organizations used to guide leadership strategies intuitively to create a culture of inquiry and respect for nurses and the care they provided. Today, we are fortunate to have RNAO's Healthy Work Environment (HWE) BPGs (see Chapter 3, *Creating Healthy Workplaces: Enabling Clinical Excellence*)—including the *Developing and Sustaining Nursing Leadership* BPG (RNAO, 2013c) and the RNAO Implementation Toolkit (2012)—that articulate useful leadership practices and implementation strategies.

The *Developing and Sustaining Nursing Leadership* BPG provides an organizing framework to guide leadership behaviours to result in "a healthy work environment and healthy outcomes for the patient/client, nurse, team, organization and the system" (RNAO, 2013c, p. 16) (see Figure 7.1). This framework addresses the context for leadership capabilities, at the organizational and personal levels, transformational leadership practices, and relevant outcomes to be considered. The guideline is supported by significant empirical evidence and is both helpful and relevant to nurse leaders in a variety of roles. Further, it describes:

- Leadership practices that result in healthy outcomes for patients/clients, organizations, and systems
- Anticipated outcomes of effective nursing practices

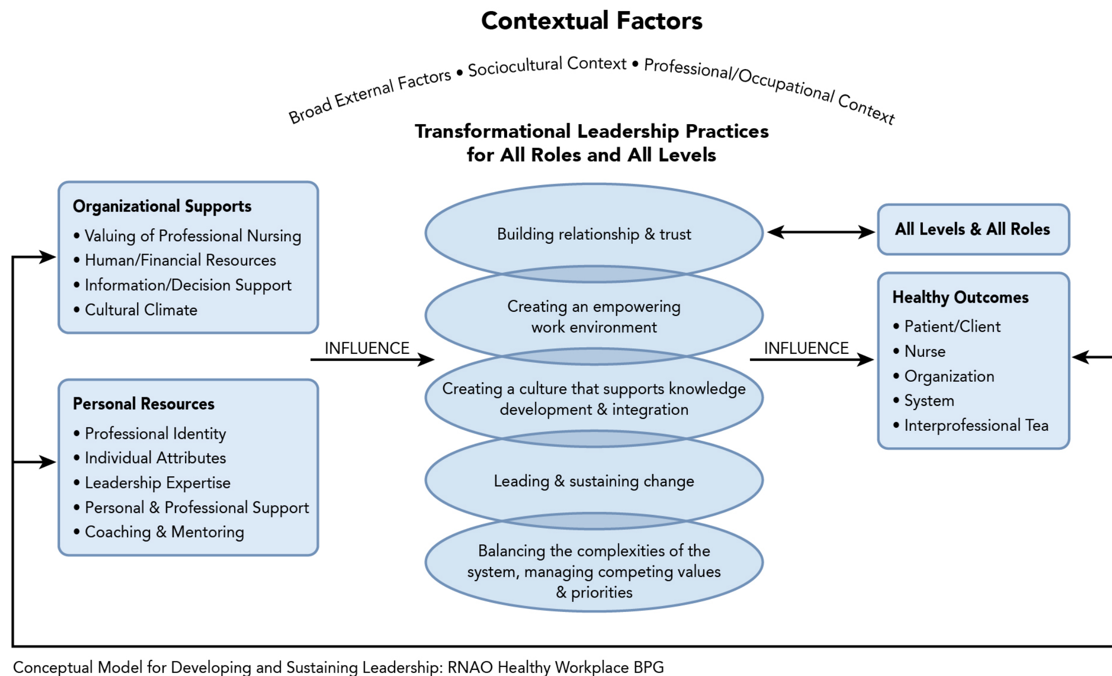

FIGURE 7.1 Conceptual model for developing and sustaining leadership.
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Following is a series of case studies reflecting the successful work of the three organizations using the BPSO Designation strategy and related supports to develop an evidence-based culture in their organizations.

CASE STUDY

SAINT ELIZABETH

Saint Elizabeth is a Canadian social enterprise that provides home care, health solutions, and education to people where they are and when they need it. With more than 100 years of community health expertise, the not-for-profit charitable organization has provided 50 million care exchanges in the past decade alone and currently employs a team of 9,000 nurses, rehabilitation therapists, and personal support workers. Saint Elizabeth staff is highly mobile, geographically dispersed, and anchored in local neighbourhoods. Care is delivered in home and community settings across Canada to children, adults, and seniors, with services ranging from prevention and wellness to post-op care and the management of chronic conditions such as diabetes, wounds, and hospice palliative care.

GETTING STARTED

In the early days, before the advent of the BPSO Designation, Saint Elizabeth took a leadership role in pilot testing two RNAO guidelines: *Assessment and Management of Venous Leg Ulcers* (2004a) and *Establishing Therapeutic Relationships* (2006b). At that time, there was a paucity of published literature to guide the process of integrating evidence into clinical practice.

Accordingly, we used Rogers' Diffusion of Innovations Theory (Rogers, 1995) to explore how, why, and the rate at which new ideas spread. During the pilot, the guidelines were implemented at Saint Elizabeth as well as two other partner organizations. As a BPG implementation pioneer, this experience informed our early learnings related to

infrastructure requirements, the role of organizational culture, and the need for tailored education strategies. The pilots allowed us to learn on a small scale before implementing guidelines across the organization to achieve the BPSO Designation.

MOVING TOWARD EVIDENCE-BASED PRACTICE

In 2003, Saint Elizabeth's vision was to be a "knowledge and care exchange company"—one that created, managed, utilized, and shared knowledge for the advancement of patient care and health outcomes, with a strong evidence base underpinning both decision-making (i.e., evidence-informed decision making [EIDM] [DiCenso, Ciliska, & Guyatt, 2005]) and healthcare practice. Working with the EIDM model (see Figure 7.2) and in partnership with our staff, we set forth to create a climate of critical inquiry and a culture that supported the use of evidence from the bedside to the boardroom. The opportunity to broadly implement and evaluate BPGs in partnership with RNAO provided the resources, focus, and a strategic catalyst for advancing our vision.

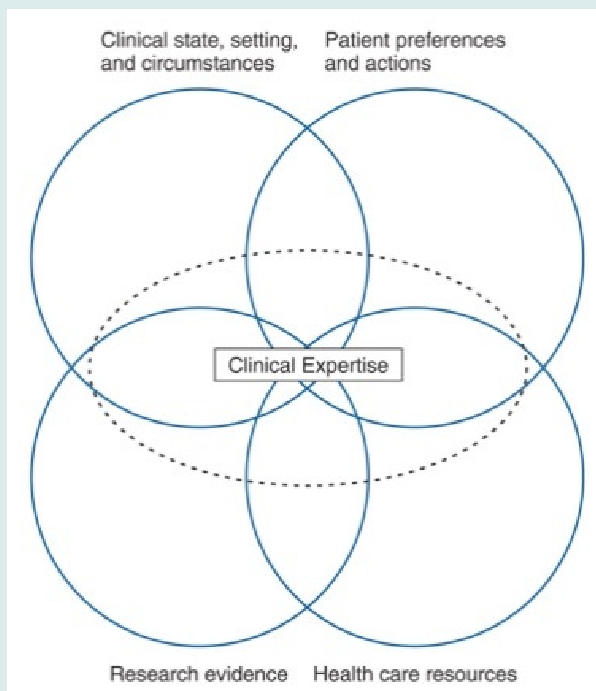


FIGURE 7.2 A model for evidence-based clinical decisions.
DiCenso et al., 2005. Used with permission.

To advance our knowledge and support a rigorous approach, a site visit was made to the University of Iowa Hospital (UIH), a well-known innovator and leader in the field of evidence-based practice. During discussions with staff at many levels—from direct care to executive leadership—we explored the role of organizational culture, leadership, infrastructure, processes, data collection, analysis, and reporting. An appreciative inquiry (AI) (Stavros, Godwin, & Cooperrider, 2015) approach was then used to document and categorize successful strategies into key themes such as education, reward and recognition, performance expectations, infrastructure supports, info-structure, culture, and external environment. Stavros et al. (2015) suggest that AI is a fundamental shift in perspective that focuses on the best in the organization and its people, leading to recognition of strengths and inspiring hope about new possibilities. This approach impacted our individual (micro), organization (meso), and system (macro) level strategies, which were tailored and aligned to our organizational environment and formed the basis of our implementation road map.

To ensure success moving forward, Saint Elizabeth put several structures in place that were consistent with the BPSO requirements (RNAO, 2017). First, a Project Leader was designated to ensure strategic alignment with the organization's vision of knowledge leadership. Second, internal structures were created to achieve integration and alignment with other activities and priorities throughout the organization. At the outset, we established a BPSO Steering Committee that included senior and local leaders as well as representation from professional practice, service delivery, research, and communications. Implementation was further supported by a dedicated project management team. Once the committee structures were in place, an Environmental and Stakeholder Assessment as outlined in the *RNAO Toolkit: Implementation of Best Practice Guidelines* (2012) was conducted in all implementation sites.

SUCCESSES

As a Designated BPSO, Saint Elizabeth has been involved in testing, developing, and implementing over 30 RNAO Best Practice Guidelines. Initially, we decided to implement one guideline at a time across 24 local sites, in order to promote staff engagement and full integration of the BPG. The project management team worked closely with

each site to creatively solve problems, identify collective strategies, and meet overall timelines. This kept us on track and promoted collaboration and recognition between corporate and local teams. The clinical network was complemented by a strong working relationship with the local site manager, who helped ensure adequate staffing to deliver high-quality care, data collection, and evidence-based decision-making based on clinical outcomes.

The BPG initiative helped us to improve clinical outcomes, knowledge transfer, and professional relationships across the organization. Knowledge flowed from our advanced practice consultants at the corporate level, to the local clinical resource network, and out into community practice. In some specialty areas such as hospice palliative care, local clinical resource nurses played an active role as guideline Champions, providing consultation and mentoring to their peers (Ploeg et al., 2010). The BPG initiative provided the Champion preparation workshops and connection to a broad BPG Champion Network, and helped us identify the clinical and geographic areas where our Champion network was strongest, as well as the areas that needed further support and development. Since the initial implementation of the BPG related to wound care, excellent outcomes have been maintained:

- 100% wound reduction occurs at 30 days, exceeding our target every quarter year over year
- 100% of wounds healed at 12 weeks or less

In addition, in palliative care, related to pain and intensity we have:

- Successfully maintained threshold for pain and distress intensity for palliative patients, exceeding best practice targets (≤4/10) recommended by Cancer Care Ontario (Cancer Quality Council of Ontario, 2017)

To meet the BPSO requirements and implement and sustain BPGs, strategies for knowledge transfer included educational packages, documentation, and policies and procedures based on BPG evidence. Education was provided through a "train-the-trainer" approach that was flexible to local needs and designed to actively involve direct-care nurses based on their work schedule and practice reality. While we initially planned to deliver education during weekly team meetings, we quickly recognized that a more creative approach was required. Accordingly, an eLearning program and virtual resource center was created that could be accessed from anywhere, 24/7. Nurses were further supported by virtual Communities of Practice that provided a forum for peer and expert support, as well as access to literature.

Through our work with indigenous communities across Canada, Saint Elizabeth saw an opportunity to further spread BPGs and support healthy outcomes beyond our own organization when we incorporated the guidelines into our First Nations, Inuit and Métis Program. For example, diabetes and diabetic foot ulcers are a significant challenge in First Nation communities (Martens, Martin, O'Neil, & MacKinnon, 2007), and education and skills in treating diabetic foot ulcers was a key focus of our BPG work. In Manitoba, we partnered with the Assembly of Manitoba Chiefs (AMC) on a Health Canada–funded project that focused on the prevention, treatment, and care of diabetic foot ulcers within a wait-times framework. As part of this project, we incorporated the *RNAO Assessment and Management of Foot Ulcers for People with Diabetes BPG* (2013a) into the education for community nurses and health workers and provided skills training, resources, and equipment to help with ulcer care (Saint Elizabeth Health Care and Assembly of Manitoba Chiefs, 2011). This initiative demonstrates creativity, commitment, and success in spreading and sustaining evidence-based practice to other locations and cultures. AMC went on to obtain federal funding to assist several Manitoba communities with technology to track patients and ensure treatment and follow-up.

Ensuring adequate treatment for people with diabetes also helped Saint Elizabeth strengthen external relationships in Ontario. For example, while implementing the BPG for *Subcutaneous Administration of Insulin for People with Type 2 Diabetes* (RNAO, 2009), it became evident that we were seeing a large population of patients that required more holistic care for diabetes. This led us to implement the guideline for *Reducing Foot Complications for People with Diabetes* (RNAO, 2004b, 2007b). Additionally, it highlighted the need for wound-dressing products and offloading devices for this population, and as a result, we improved communication with our funding partners and strengthened our alliance with local hospital clinics and physicians specializing in wound care.

"When nurses adhered to and advocated for use of recommendations in the RNAO's BPGs, patients' care has improved, in some cases, dramatically. The BPGs now help nurses structure client care and 'articulate what we're trying to do and why.' They also boost nurses' confidence when talking to patients and other practitioners."

—Kay McGarvey, Saint Elizabeth CRN, Toronto SDC

CHALLENGES

The nature of home care and our multisite environment presented some unique challenges related to BPG implementation. Community health nurses are knowledge workers who are highly autonomous, mobile, and geographically dispersed. Therefore, our implementation strategies had to be flexible and adaptable to this unique practice reality. At the time, our organization was growing rapidly, and many changes were taking place in the external environment that resulted in the need for ongoing recruitment and onboarding of new staff. Our orientation was revised to incorporate the BPSO initiative, and the ongoing engagement of preceptors and Champions in transferring knowledge was critical (Ploeg et al., 2010).

Another area of challenge was evaluation. Although we had a strong Continuous Quality Improvement program, much of the data we were collecting was related to the service delivery process, rather than specific clinical indicators and outcomes. The BPSO Designation helped us to improve our data-collection tools and processes to provide timely feedback on care outcomes. Moreover, as most visiting nurses were already using mobile phones, we were able to collect clinical data more easily at the point of care and follow it across visits with this technology, empowering nurses in the home to take more leadership in making decisions and changing the care plan as needed based on outcomes.

SUSTAINABILITY

Sustainability is a critical component of the BPSO Designation, and perhaps the most important factor to consider when implementing Best Practice Guidelines. If guidelines are not integrated within an organization, practice will quickly return to its previous state. To prevent this, it is important to embed the guidelines in every aspect of care delivery so that best practice becomes part of "usual care." At Saint Elizabeth, the day-to-day BPG implementation and sustainability were integrated into our Clinical Program structure. The advanced practice nurse for each specific area takes a leadership role in monitoring clinical outcomes and updating education, documentation, policies, and procedures with emerging evidence. They work with regional directors, clinical resource nurses, clinical networks, and local Champions to support ongoing education and improvements. The advanced practice nurse also supports the integration of the guidelines across the care continuum by adapting them for use in all of our healthcare services, including personal support and rehabilitation.

To foster ongoing strategic alignment, Saint Elizabeth kept the BPSO initiative within the permanent leadership role of the Manager of Knowledge Translation, under the direction of the Vice President of Knowledge, Practice and Clinical Services. This allowed us to continue to work with external partners to ensure evidence was created and used across the healthcare system. As an example, we partnered with other BPSO organizations such as West Park Healthcare Centre (see Case Study) to implement the RNAO Healthy Workplace BPG for *Developing and Sustaining Nursing Leadership* (2013c). We are also continuously involved with RNAO in creating new guidelines and resources, educating and mentoring new BPSO member organizations, and working with the collaborative RNAO/University of Ottawa Nursing Best Practice Research Centre (NBPRC). Table 7.1 outlines the BPSO requirements and opportunities through RNAO that have been and continue to be effectively used by Saint Elizabeth to support initial and sustained use of BPGs. Our ongoing relationship with RNAO has played a key role in supporting and sustaining the shift to an evidence-based culture and fostering leadership, empowerment, and professionalism amongst staff at Saint Elizabeth.

TABLE 7.1 BPSO REQUIREMENTS AND OPPORTUNITIES ENABLING IMPLEMENTATION AND SUSTAINABILITY

BPSO REQUIREMENTS SUPPORTING BPG IMPLEMENTATION	BPSO REQUIREMENTS AND OPPORTUNITIES THAT SUPPORT SUSTAINMENT
Formal BPSO Status and BPSO Designation	Membership on RNAO BPG panels
Ongoing access to BPSO Leadership team at RNAO	Member of panel to review other BPSO Proposals
Scheduled follow-up knowledge exchange sessions with RNAO and other BPSOs	Member of panel to review applications to RNAO fellowship opportunities
RNAO Toolkit (2012) and systematic approach to BPG implementation	Contributing to knowledge dissemination activities such as learning events or BPG-related conferences
Champion Workshops	Manuscript submission requirements of the BPSO Designation
Semi-Annual Status Reports required to be submitted to RNAO	Contributing data to NQuIRE and utilizing real-time reports on process and outcome indicators
Research/BPSO Liaison position required	Ongoing evaluation and research support from the RNAO/University of Ottawa Nursing Best Practices Research Centre
Practice Fellowships to support development of advanced clinical skill offered through RNAO	Mentorship work with new BPSOs to provide education and support

Perhaps the most important factors in sustaining the BPGs have been RNAO's enhanced focus on BPG evaluation through establishment of NQuIRE (Nursing Quality Indicators for Reporting and Evaluation), an international BPG-related data base system of indicators (see Chapter 16, *Evaluating BPG Impact: The Development and Refinement of NQuIRE*), and Saint Elizabeth's data collection and submission to this system through our Continuous Quality Improvement program. This process has been augmented by electronic collection of information, which is now part of our audit and feedback process. An evaluation of Saint Elizabeth's process was recently undertaken by Gifford et al. (2016), which showed that operational and clinical leaders are using the data to inform planning. Our next step is to expand information sharing with direct-care nurses to further improve practice.

"To see the evolution of our organization as one that uses evidence from the bedside to the boardroom to give the best care possible to get the best care outcomes for our clients and to engage our staff in that process . . . that's why we continue to be a BPSO."

—Nancy Lefebre
Saint Elizabeth Chief Clinical Executive and Senior Vice-President of Knowledge and Practice

THE FUTURE

Over time, organizations evolve around emerging themes that influence their future direction. In 2003, the theme of "knowledge" was informing Saint Elizabeth's evolution as a company and BPSO. Today, themes such as digitization and the consumer experience (Advisory Panel on Healthcare Innovation, 2015) are at the forefront, and as a result, BPGs and knowledge are being integrated into a digital framework that is anchored in person- and family-centered care, utilizing aspects of RNAO's *Person and Family Centred Care* BPG (2015). In this work, reflecting the approach in the BPG, our patients and their families are central in the care process as empowered, respected partners (RNAO, 2002, 2006a, 2006b, 2010, 2014). In the future, evidence-informed decision making (EIDM) will continue to evolve with more emphasis on management decision-making in addition to clinical care. This is already happening within and outside of our organization based on the rapid growth of big data and predictive analytics (Canada Health Infoway, 2013). In response to growing consumer engagement in health, outcome measures will eventually include more patient reported outcomes and a larger focus on the patient and family experience. The ongoing integration and sustained used of Best Practice Guidelines will be based on innovative knowledge-transfer strategies as we create and deliver new models of care, automate our processes, and design the practice environment of tomorrow.

CASE STUDY

WEST PARK HEALTHCARE CENTRE

West Park Healthcare Centre (the Centre) is located in Toronto, Ontario, Canada, and provides a range of post-acute and tertiary rehabilitation services aimed at assisting people to "get their life back" following life-altering illness or injuries. Rehabilitation and complex continuing care are core to the Centre's hospital-based programs and include inpatient, outpatient, outreach, and day services. Subspecialization is the hallmark of the Centre's program offerings, which are focused on helping individuals with difficult health challenges (such as advanced lung disease, tuberculosis, long-term ventilation, strokes, acquired brain injuries, amputation, and traumatic injuries) reclaim their lives and realize their potential.

GETTING STARTED

Over the years, the Centre's programs and services have evolved to meet the changing needs of our patient populations as well as various health system changes. Recruitment and retention challenges, along with significant financial pressures, led the Centre on a path to transforming its care delivery model in the late 1990s. In concert with changes to the care delivery model, the professional practice portfolio was realigned to ensure the successful implementation of the new care delivery model and concomitant evolution of the practice setting. A centralized professional practice structure was established, led by a director of professional practice, and supported by new roles that included advanced practice nurses and nurse practitioners who were focused on advancing professional practice and improving the quality of patient care.

Our early experience with the RNAO BPGs began prior to our BPSO candidacy, with quality-improvement work in the area of pressure (wound) injury prevention and management. At the time, one of our advanced practice nurses (APNs) was involved in the first RNAO BPG development panel on pressure (wound) injuries and led the Centre's improvement work in this area. Advanced Practice Nurses at the Centre are registered nurses prepared at the graduate level with in-depth nursing knowledge and clinical expertise to meet the needs of the patients. Post-implementation results demonstrated a 55% improvement in the incidence of pressure injuries and provided a compelling case for the ongoing commitment to a comprehensive and sustained approach to BPG uptake.

MOVING FORWARD WITH EVIDENCE-BASED PRACTICE

The changes in our professional practice structure provided clear, senior accountability for professional practice and enhanced the qualifications for practice leaders, thereby positioning the Centre to move forward with the creation of an evidenced-based practice setting. The Centre's core values of respect, innovation, excellence, and accountability anchored our commitment to developing an evidence-informed culture.

Recognizing the cultural shift that would be required to move in this direction, the Lawler's Star Model (1996)—a conceptual framework for cultural alignment—was utilized to guide our implementation efforts (Galbraith, 2001; Lawler, 1996), making sure that all our organizational structures and processes were aligned with and could support an evidence-based culture. See Figure 7.3.

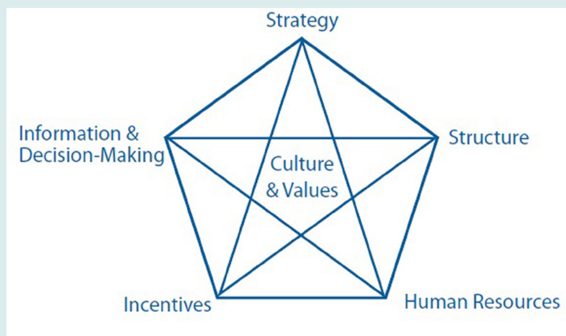


FIGURE 7.3 The Star Model.
Galbraith, J. R. Retrieved from http://www.jaygalbraith.com/services/star-model. Used with permission.

By the time we received our BPSO Designation in 2006, the Centre was in the process of implementing three additional BPGs: *Assessment and Management of Pain* (RNAO, 2013b); *Client Centered Care* (RNAO, 2002); and *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2011b).

Similar to the Saint Elizabeth case study, a systematic approach to the implementation and evaluation of the BPGs was put in place, using project management methodology and drawing on strategies from the RNAO BPSO consultation and coaching support and the RNAO Implementation Toolkit (2012). Our Advanced Practice Nurses led the majority of implementation teams. Implementation-focused education and approaches were developed, both internally and with external assistance, and reflected creative strategies such as puzzles, role-playing, and various experiential learning processes to engage staff. A key difference in the Centre's approach was the creation of an interprofessional working group to build linkages across disciplines and programs to promote collaborative practice.

SUCCESSES

The nurse leaders who navigated this journey brought clear vision and foresight to the work, along with proven implementation experience, content expertise, and passion. In addition to personal resources, these nursing leaders influenced practice and outcomes through relationship building, creating an empowering work environment, and leading change (RNAO, 2013c). Although we experienced turnover in some leadership positions (discussed later in "Challenges"), consistent executive leadership enabled a continued focus and commitment to the BPSO mandate.

The linchpin of our success, then, was the pivotal role of our nursing leaders: resource nurses, advanced practice nurses, chief nursing officers, and chief nursing executives. Each contributed to our success through a deep understanding of:

- The fundamental benefits of the BPGs in advancing patient care and clinical practice
- The alignment of the BPSO mandate with the organization's vision and values
- The changing needs of our patients
- The imperative for quality improvement, innovation, and sustainable care delivery solutions

Shifting the culture of health organizations toward evidence-based practice is a big undertaking, and many stakeholders played a key role. Senior leaders were committed and engaged throughout the process, providing critical consideration in our implementation approach and thoughtful decisions on how and where to launch new BPGs. This helped to create a compelling "Call to Action" throughout the organization, successful co-created approaches, and an effective multimodal communication strategy.

Also key to the Centre's success was an interprofessional project team that ensured a collaborative approach to guideline implementation, clinical evaluation, and research. Interprofessional team members included APNs in gerontology and rehabilitation, clinical informatics, psychology, clinical pharmacy, and medicine. This approach encouraged expression of diverse perspectives and led to guideline adaptations that were specific to our patient populations, as well as implementation and evaluation strategies specific to our practice setting context. We also drew on the Community of Practice that was available to us through RNAO, which provided access to clinical experts, education, mentorship, and knowledge exchange opportunities for our staff.

Today, we continue to realize the benefits of sustained BPG use as evidenced in a number of human resource and clinical outcome indicators. Indicators reflecting job satisfaction consistently outperform the benchmark, as demonstrated in the results of our 2013 employee engagement survey results (see Figure 7.4).

"The scholarship domain of my CNS practice has been supported through the BPSO work in enabling me to make contributions to the development of nursing knowledge and evidence-based practice."

–Barbara Anderson (Cowie), CNS/Nurse Continence Advisor

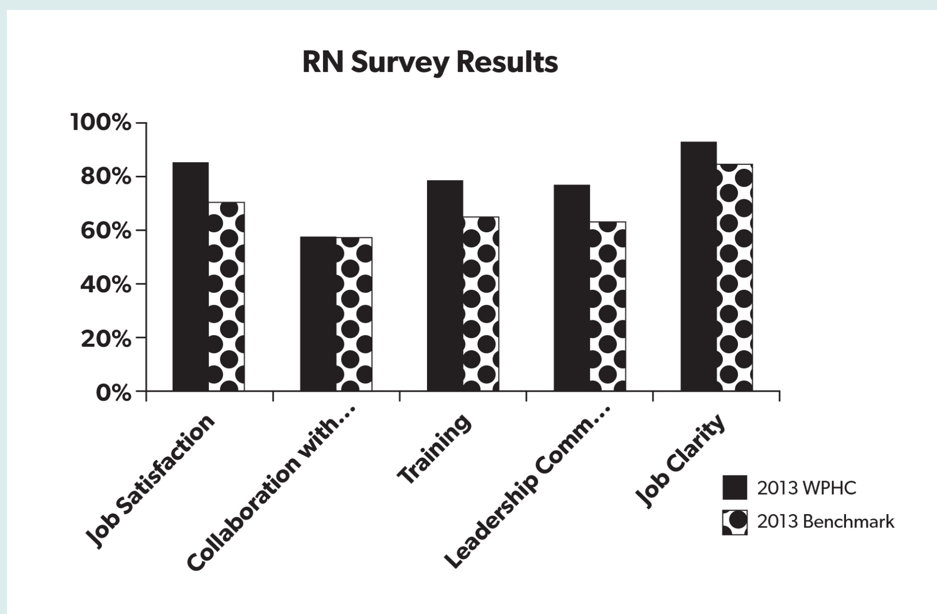


FIGURE 7.4 NRC, Employee Experience Survey, 2013. Used with permission.

Clinical outcomes also continue to improve, as demonstrated by the implementation of the pain BPG resulting in a reduction of more than 50% of patients reporting pain over several years, and improving our performance well beyond provincial average. See Figure 7.5, which is based on data compiled by West Park Healthcare Centre from the Canadian Institute of Health Information Complex Continuing Care Reporting System Facility Level Reports for West Park Healthcare Centre, 2006–07, 2009–10, 2012–13, 2015–16, and 2016–17 Q1–3.

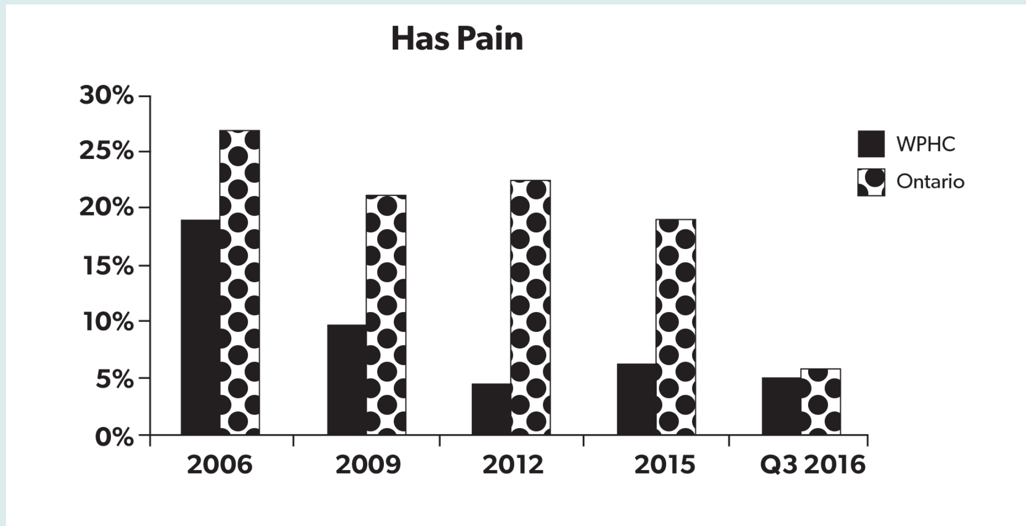


FIGURE 7.5 Reported Pain, West Park Healthcare Centre versus Ontario Scores. Used with permission.

"Critical to our success were the nurse leaders who navigated the Centre on this journey and provided clear vision, determination and foresight to the work. As a BPSO, West Park's BPG implementation journey has encouraged a spirit of inquiry, enabled interprofessional collaboration and inspired the practice of our staff!"

–Anne-Marie Malek, President and CEO

CHALLENGES

One of the biggest challenges in being an early adopter was that we were the only rehabilitation and complex continuing care hospital designated as a BPSO in the beginning. We did not have the benefit of being able to consult with a peer hospital through the process or while developing implementation resources. Implementation and sustainability require a long-term view of the allocation of resources, including the ongoing engagement and development of staff, the redesign of care processes, and the development of various clinical tools such as the incorporation of BPGs into the electronic patient record.

Environmental factors such as competing practice and corporate initiatives, clinical events such as the outbreak of severe acute respiratory syndrome (SARS) in Ontario, Canada in 2003, as well as senior nursing and clinical leader turnover presented further challenges to our implementation of the BPGs. Turnover of nursing leaders had a profound impact as it resulted in a loss of expertise and created a "stop/start" effect on relationships and engagement with staff.

However, adversity helped us reaffirm our commitment to the BPSO Designation mandate, engage new leaders, and become more flexible and creative in our implementation approaches. In fact, many of these challenges were made easier through our partnership with RNAO and the exchange of ideas and shared learning, which provided support to the APNs leading the implementation. Today one of our greatest challenges continues to be the enduring effort toward practice development, an enabling methodology that supports the ongoing implementation and sustainability of BPGs.

SUSTAINABILITY

More than a decade after our BPSO Designation, we have realized the value of this work time and time again and remain committed to our BPSO mandate. Committed leadership and an empowered practice environment

are essential to sustaining the work. Our sustainability strategies have included the use of technology to embed BPGs in nursing documentation, access to clinical data to measure outcomes, and continued engagement in the RNAO activities outlined in Table 7.1. We have been steadfast in our vision to create an evidenced-based practice setting, and the value of that commitment has been pivotal to improving patient care and advancing professional practice at the Centre.

To facilitate and sustain practice change, the Centre adopted the practice development methodology (Manely, McCormack, & Wilson, 2008) to guide systematic change and enable nurses to transform culture and the context of care. According to Manely et al. (2008), practice development is based on a person-centered philosophy and supported by facilitators who help staff reflect on their practice identifying the nature of the experience and its impact on patients and on them personally and professionally. This methodology aligned well with RNAO's healthy workplace BPGs (see Chapter 3, *Creating Healthy Workplaces: Enabling Clinical Excellence*) and the knowledge-translation literature as reflected in RNAO's Implementation Toolkit (2012) and has guided our communications, knowledge building, behaviour change, recognition, and integration of BPGs into the fabric of the Centre. Through a facilitative strategy, teams are empowered to focus on excellence through continuous improvement by setting and monitoring standards and targets.

At the same time, increased access to clinical information and decision support have further advanced clinical and administrative decision-making. Quality indicators and the balanced scorecard approach highlighted performance successes and opportunities. In addition to existing quality indicators, RNAO's NQuIRE provides a comprehensive data system to systematically monitor human resource structure, process, and outcome indicators, increasing our ability to evaluate the outcomes of BPG implementation. The inventory of available BPGs is reviewed on an ongoing basis as we identify gaps and plans for the future. For example, our focus on palliative care led to using the *End of Life Care During the Last Days and Hours BPG* (RNAO, 2011a), to develop and implement comfort interviews. In fulfilling a BPSO Designate requirement, and in keeping with the professional practice goals of the staff, a manuscript detailing the process and outcomes was then written and accepted for publication in a journal as a means to disseminate our learnings and findings (Konietzny & Anderson, 2018).

"BPGs provide an evidence informed foundation from which practice can be developed. That foundation is critical to the advancement of nursing care and improved patient outcomes."

–Barbara Bell, former Chief Nursing Executive

THE FUTURE

With the increasing complexity of patient populations, BPG implementation and sustainability will continue to be essential to the pursuit of excellence in clinical practice and patient care. As a BPSO, we have seen just how fundamental the implementation of BPGs has been to improving patient care and advancing professional practice at the Centre. BPGs have and will continue to encourage a spirit of inquiry, enable interprofessional dialogue, and inspire the practice of nurses at various stages of their careers (RNAO, 2007a). As our programs and services evolve to meet the changing needs of the patients we serve, so must practice and care delivery. RNAO's rigorously developed BPGs, and their attention to knowledge transfer and evaluation, are effective tools for accomplishing this.

CASE STUDY

SUNNYBROOK HEALTH SCIENCES CENTRE

Sunnybrook is a large academic health sciences center that is fully affiliated with the University of Toronto, located in Toronto, Ontario, Canada. With 1.2 million patient visits each year, Sunnybrook has established itself across three campuses and is home to Canada's largest trauma center. Sunnybrook has nine clinical programs and 10,000 staff who support our vision: "To invent the future of healthcare."

GETTING STARTED

Sunnybrook Health Sciences Centre (SHSC) began its BPSO journey in 2012 with the primary purpose of selecting and implementing RNAO BPGs that would have the greatest impact on the health outcomes and well-being of our patients. The BPSO initiative was aimed at establishing ways to integrate new learning and evidence into practice and at increasing communication about patient outcomes and care delivery. We also recognized that the initiative aligned well with our Interprofessional Collaboration Strategy to foster collaborative relationships. Consequently, at the onset of our BPSO candidacy, we were deliberate in leveraging the talent and experience of *all* our staff with a vision "to achieve a collaborative interprofessional practice environment that focuses on what matters and what is important to patients." To date, we have been successful in meeting our objectives and the BPSO deliverables, and as a result we have realized significant impacts to practice, education, research, and leadership.

As part of achieving these results, we invested significant time and energy in developing a comprehensive plan in which we:

- Used the RNAO Implementation Toolkit (2012) as a map
- Connected with leaders at organizations with prior BPSO experience
- Built our own knowledge and expertise through formal learning programs such as the RNAO BPG Institute
- Adopted frameworks for implementation and sustainability
- Created an Interprofessional Best Practice Steering Committee and supporting infrastructure
- Engaged programs to identify opportunities for focus
- Developed an implementation plan, staging best practice work across the years of BPSO candidacy

In addition, in a large and complex organization, we understood the necessity of giving this work distinct recognition. Together with our Communications and Media Leaders, we created a tagline—"Best Practice Matters"—and visuals (Figure 7.6) that were and continue to be used to highlight best practice through communication and awareness-raising strategies.

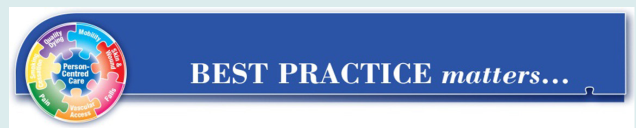


FIGURE 7.6 Sunnybrook Health Science Centre's "Best Practice Matters" logo.
Used with permission.

SUCCESSES

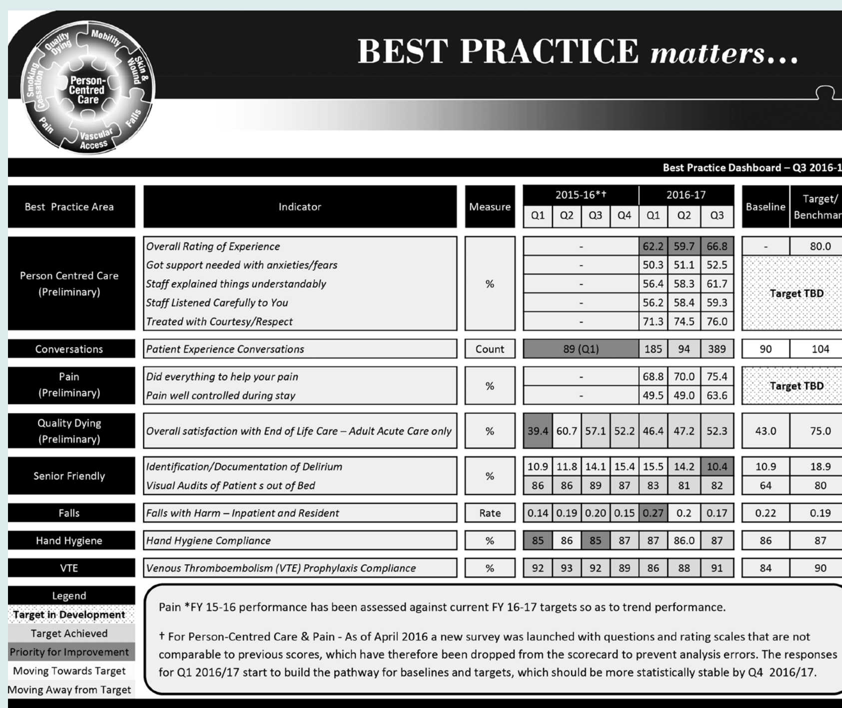
At the beginning of our BPSO candidacy, one of our key successes was the significant alignment created with our Nursing Council, a body that has nursing representation from units across the hospital. From the first year of candidacy to today, Nursing Council members have been engaged as key stakeholders: informing, advising, being involved in implementation, and serving as the conduit for best practice with other health professions. The Best Practice Steering Committee helped to ensure the inclusion of BPSO work in nonclinical areas such as human resource hiring practices, staff orientation, performance reviews, and the 2017–2020 Quality Strategic Plan.

Aligning BPGs within our Quality Improvement Plans has been a focus since the beginning, and we have continued to add indicators for person-centered care, falls risk reduction, patient mobilization, and delirium accuracy over the last few years. This provided additional visibility of these interventions both internal and external to the organization. As well, a BPG Dashboard (Figure 7.7) was created to align with our corporate Quality Improvement Portal and profile quarterly metrics for each best practice. Over time and with support, teams are growing in their ability to review performance, discuss improvement, and create local Action Plans to enhance patient outcomes. They use three guiding questions to assist them in reviewing their data:

1. What is our current status?
2. How are we moving toward the target?
3. What do we need to do to continue to improve?

"Clinicians will make things happen, when they understand why change is necessary."

–Sonia Dyal
APN of the Mental Health Department & Elaine Avila, Clinical Educator of inpatient oncology units



BEST PRACTICE *matters...*

Best Practice Dashboard – Q3 2016-17

Best Practice Area	Indicator	Measure	2015-16*† Q1	2015-16*† Q2	2015-16*† Q3	2015-16*† Q4	2016-17 Q1	2016-17 Q2	2016-17 Q3	Baseline	Target/ Benchmark
Person Centred Care (Preliminary)	*Overall Rating of Experience*	%	-				62.2	59.7	66.8	-	80.0
	Got support needed with anxieties/fears		-				50.3	51.1	52.5	Target TBD	
	Staff explained things understandably		-				56.4	58.3	61.7		
	Staff Listened Carefully to You		-				56.2	58.4	59.3		
	Treated with Courtesy/Respect		-				71.3	74.5	76.0		
Conversations	*Patient Experience Conversations*	Count	89 (Q1)				185	94	389	90	104
Pain (Preliminary)	*Did everything to help your pain*	%	-				68.8	70.0	75.4	Target TBD	
	Pain well controlled during stay		-				49.5	49.0	63.6		
Quality Dying (Preliminary)	*Overall satisfaction with End of Life Care – Adult Acute Care only*	%	39.4	60.7	57.1	52.2	46.4	47.2	52.3	43.0	75.0
Senior Friendly	*Identification/Documentation of Delirium*	%	10.9	11.8	14.1	15.4	15.5	14.2	10.4	10.9	18.9
	Visual Audits of Patient s out of Bed		86	86	89	87	83	81	82	64	80
Falls	*Falls with Harm – Inpatient and Resident*	Rate	0.14	0.19	0.20	0.15	0.27	0.2	0.17	0.22	0.19
Hand Hygiene	*Hand Hygiene Compliance*	%	85	86	85	87	87	86.0	87	86	87
VTE	*Venous Thromboembolism (VTE) Prophylaxis Compliance*	%	92	93	92	89	86	88	91	84	90

Legend
Target in Development
Target Achieved
Priority for Improvement
Moving Towards Target
Moving Away from Target

Pain *FY 15-16 performance has been assessed against current FY 16-17 targets so as to trend performance.

† For Person-Centred Care & Pain - As of April 2016 a new survey was launched with questions and rating scales that are not comparable to previous scores, which have therefore been dropped from the scorecard to prevent analysis errors. The responses for Q1 2016/17 start to build the pathway for baselines and targets, which should be more statistically stable by Q4 2016/17.

FIGURE 7.7 Sunnybrook Health Sciences Centre's BPG data dashboard. Used with permission.

As a result of these quality initiatives, we have seen patient outcome improvements including the following:

- Pressure ulcer incidence reduction from 6.4% (2011) to 4.7% (2016)
- Quality Dying percent positive satisfaction scores, rising from 43% Q4, 2012/13 to 68% Q4, 2016/17
- Positive trends in both our patient experience and pain results on the new Canadian Patient Experience Survey tool
- Falls with harm/1,000 patient days meeting target in 8 of 12 quarters
- Mobilizing 80% of patients three times daily across 31 patient care units, for over 3 years
- Delirium accuracy, prevention, and management enhancements
- 2,395 Advanced Care Planning conversations documented since 2015

Other work is ongoing where future organization-wide impact is anticipated, including in areas related to violence management and prevention and managing high-risk behaviours.

SHSC began entering data within the RNAO's NQuIRE comprehensive data system in 2016. Data are being submitted for three RNAO Best Practices Guidelines—*Assessment and Management of Pain* (2013b), *Prevention of Falls and Fall Injuries in Older Adults* (2011b), and *Assessment and Management of Pressure Injuries for the Interprofessional Team* (2016)—from units in our Oncology, Rehab, Trauma, and Musculoskeletal Programs. We are in the relatively early stages of submission, anticipating the data will provide greater understanding of our process and outcome measures and the interplay with our human resources structural indicators (e.g., staffing, skill mix, absenteeism, and agency use).

In addition to being part of the Quality Improvement Program, staff at Sunnybrook is also encouraged to participate in Practice Based Research & Innovation (PBRI) activities. A very interesting part of our story has been the increasing interest and alignment between the two initiatives. As testament to this, of the 26 PBRI applications submitted for work in 2017/18, 11 are directly linked to best practice priorities. For each of these submissions, a Best Practice Lead serves as mentor, facilitating connectivity of the work and sustainability post-fellowship. Previous fellowship opportunities have achieved significant results, such as a 40% rise in patient mobilization, a 34% rise both in pain assessment every 4 hours and in pain reassessment post analgesic administration, change in dressing-change frequency, and adoption of a care-bundling tool.

A tremendous success has been the development of over 550 interprofessional direct-care staff as Champions, exceeding the 15% BPSO requirement. Champions are individuals who bring passion to patient care improvement and actively promote, educate, and inspire others to implement change and to adopt evidence into everyday care. Each Champion participates in an introductory Quality Improvement workshop endorsed by the RNAO as consistent with the RNAO BPG Champion Network Curriculum and led by our Quality and Patient Safety Department. The workshop provides Champions with the fundamental knowledge and tools to lead and sustain change. Then they work with their local teams to lead quality-improvement work based on BPG implementation and showcase their results in hospital-wide events.

To support the Champions, we created a new and innovative role of "Best Practice Change Coordinator." Change Coordinators are clinicians who know how things work, have connections with colleagues, and can translate theory into practice. In each of our candidacy years, we hired three interprofessional direct-care staff to mentor Champions approximately 2 days per month. Due to the success of this strategy, this important role has been sustained. As a result of this development opportunity, many Champions have gone on to post-graduate studies, while each of our Change Coordinators has moved on to formal leadership roles.

"As a Best Practice Change Coordinator I am learning and growing through experiences with Champions and leaders across the hospital. I am most proud to feel that together we are improving care for our patients."

–Marcia Fisher, Best Practice Change Coordinator

CHALLENGES

At Sunnybrook, we are thrilled to see the many accomplishments that have been achieved through our BPSO journey. As with any journey, there have been bumps in the road, and twists and turns that have caused us to reflect and challenge ourselves to ask, "Could it be even better if . . . ?" Limited time, competing demands, and advancing significant change in a large, multisite organization are amongst our greatest challenges. Despite their best intentions, staff often struggle to take on additional work and are challenged to find time to focus on initiatives, plan interventions, attend meetings, and engage colleagues to foster ideas for change.

We feel the solutions lie in the challenges themselves, and we continuously ask ourselves to think innovatively to:

- Bundle and integrate best practices so they are not viewed as additive
- Influence leaders' perspectives to help them recognize that modeling BPGs is one of the greatest ways to influence change
- Build technology that captures data and facilitates access to what we need to know
- Engage the organization to focus and collaborate on key priorities and solutions, recognizing that some will carry greater priority at different times

We believe that when the organization is engaged in ongoing dialogue about what "even better" looks like, we can co-create a future that makes sense, is meaningful, and has great impact.

SUSTAINABILITY

We began our BPSO journey explicitly intending to establish a process that would support all our work going forward. We have developed and continued to refine aspects of our program, building on what works and evolving what does not. We have a large Champion delegation, engaged local leaders, true credibility for best practice throughout the organization, and reporting mechanisms that have been ingrained and are aligned with key organizational priorities. Best Practice has had the support of Operations Directors who have made this work a priority within their programs. Reporting occurs on a regular basis to our Interprofessional Quality Committee, which provides additional advice and support. We also continue to take advantage of all the RNAO activities as outlined in Table 7.1. While we still have much to do, the structures clearly are in place to sustain Best Practices into the future.

THE FUTURE

At Sunnybrook, we are working very hard to continuously develop mechanisms to support Champions and enable them to know easily where focus is required to optimize patient outcomes and improve the patient experience. A formidable practice change that has resulted from this work is the identification and implementation of a system-wide approach to patient engagement. In 2012, prior to the development of the related RNAO BPG, *Person and Family Centred Care* (2015), 158 patient and family partners and 238 staff were asked to identify the recommendations needed to move forward with a person-centered approach to care. As a result of ongoing stakeholder engagement, and with the support of RNAO's BPGs, Sunnybrook is integrating consistent processes to standardize engagement and promote a seamless system of care for our patients.

We are also very excited about the recent launch of Sunnybrook's new Quality and Strategic Plan that not only articulates the key work that is needed across the organization but also engages staff in action-oriented improvement through quality conversations. We continue to share stories at our hospital—stories of connection and of inspiration, of care experiences and leadership. We are learning and growing together, endeavouring to ensure optimum patient outcomes are an obsession for all.

REFLECTIVE QUESTIONS

Thinking about the three case studies presented in this chapter:

1. What is the context for BPGs in your organization?
2. How might you leverage communication technology such as RNAO's BPSO Community of Practice (which connects all BPSOs around the world through a secure, technology-enabled sharing and discussion platform) in your implementation of BPGs?
3. Which of the leadership practices outlined in RNAO's Leadership BPG (2013c) would be most beneficial in beginning to implement BPGs within your organization?
4. Which leadership practices would be most beneficial in sustaining BPGs within your organization?

CONCLUSION

In conclusion, implementing and sustaining evidence-based practice is an important step in realizing improved care delivery and quality outcomes. Leadership is required at all levels of a BPSO, along with strategies that change and evolve over time. Leaders in the first BPSO pioneer cohort (first two case studies) took a brave step into the unknown, using many new educational techniques and electronic platforms, emerging evidence on implementation science, and tools and resources that were being developed "on the run." Fortunately, the BPSOs that followed (the Sunnybrook Health Sciences Centre case study) were able to learn from these experiences and "leap frog" forward in developing new approaches to engagement, implementation methods, and reporting systems. Our hope is that the discussion of our experience will provide some insight for others on or considering this journey. Although it is not for the faint of heart, the effort is very worthwhile as the use of BPGs ultimately improves outcomes for patients, nurses and other providers, health organizations, and the health system as a whole.

KEY MESSAGES

This chapter has outlined the experience of three BPSOs that implemented and sustained numerous RNAO BPGs over the past 18 years. Although each organization has had a unique experience, we found several common key messages across the organizations. Many of our insights build on the five transformation leadership practices found in the *Developing and Sustaining Nursing Leadership* BPG (RNAO, 2013c).

BUILD RELATIONSHIPS AND TRUST

Implementing and sustaining BPGs really comes down to listening to staff through appreciative inquiry mechanisms (Stavros et al., 2015) and working with them in order to provide the best knowledge possible and build teams and partnerships. Therefore, communication with stakeholder groups throughout the implementation stage is paramount to keeping everyone engaged. Understanding the organization's vision and strategic alignment of evidence-based practice is imperative. A key lesson learned was that although it is important to have a solid communication plan during implementation,

it is equally as important to sustain internal communication and have a strategy that will continue to profile, celebrate, and recognize BPSO initiatives.

CREATE AN EMPOWERING WORK ENVIRONMENT

The work environment has a significant impact on care delivery and is an important aspect of implementation and sustainability. Staff must feel that they are respected and have the professional knowledge and skills they need to perform their roles. It is important that the staff feels part of a shared vision and understand that best practice achievements are the result of coordinated efforts from all staff. Time, planning, focus, leadership, structure, and resources are all critical inputs to evidence-based practice. While the initial implementation was focused on nursing, care today is delivered by interprofessional teams, which means organizations need an approach that promotes interprofessional collaboration in order to empower all workers and sustain momentum across disciplines. As well, it is imperative to have Champions at all levels of the organization to raise awareness about the use of evidence and to celebrate those using the guidelines to achieve quality care.

CREATE A CULTURE THAT SUPPORTS KNOWLEDGE DEVELOPMENT AND INTEGRATION

Part of an empowering work environment also includes a culture that supports knowledge development and integration. This vision needs to trickle down from senior management to the program level, where experts in clinical care help select appropriate guidelines for the setting, adapt them to suit the organization, and translate them into standardized or customized recommendations. Education needs to be available to all staff, and knowledge needs to be integrated into documentation systems for point-of-care data collection into the Continuous Quality Improvement system. These outcomes need to be reviewed through data dashboards in order to help identify areas of focus and improvement.

LEAD AND SUSTAIN CHANGE

Change can be difficult! It is a process that takes time and requires multiple strategies to achieve in practice, as identified in Chapter 4 of the RNAO Implementation Toolkit (2012). Challenges can be exacerbated by high staff growth, turnover, and the need to provide staff with time out of the work environment to receive BPG and implementation science education. Project Leaders need to be nimble, resilient, committed to the initiative, and flexible in their approach. The staff needs to be coached to talk with their colleagues, support the collective to realize change, and celebrate patient outcome improvements. Leaders should also look outside their organization to other BPSOs for tools, resources, and support; to RNAO coaches and experts; and the many capacity-building opportunities provided through RNAO such as the BPSO Knowledge Exchange Symposiums.

BALANCE COMPLEX ENVIRONMENTS AND MANAGE COMPETING VALUES AND PRIORITIES

Lastly, do not expect implementation to be a linear process; there will be a lot of ups and downs along the way given the complexity of organizations and health systems. It is vitally important you advocate for the proper resources, link BPG work to other strategic initiatives, and embed BPG implementation into the day-to-day operations through various processes such as patient safety initiatives, quality assurance programs, and accreditation. When faced with multiple demands and competing priorities, take a step back, review how you can dovetail projects together, and adjust your approach. And never give up; perseverance and creativity pay off by delivering results that are good for patients, and all involved will feel proud.

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