TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development, Implementation Science, and Evaluation

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CHAPTER

8

CREATING EVIDENCE-BASED CULTURES ACROSS THE HEALTH CONTINUUM

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe the BPSO experience of four different health sector organizations: public health, hospital, primary care, and home care
- Give examples of how different organizations achieved, sustained, and continue to expand an evidence-based culture across the four health sectors
- Demonstrate the common and unique organizational implementation strategies in creating and sustaining a BPSO evidence-based culture
- Analyze which methods could be applied in other health settings to achieve BPSO Designation and an evidence-based culture

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INTRODUCTION

Healthcare today demands the understanding and implementation of evidence-based practices across the care-continuum. Patients/clients and their families should not be required to expend more time and energy thinking about the quality of the care they will receive than they do to stay healthy or to manage a specific disease. Patients/clients and their families require care at various times from a variety of providers. Transitions across the continuum of care should ideally be based on the same high-quality and evidence-based practices regardless of clinical specialty, location, day of the week, or time of day.

As the leaders of five organizations in Ontario individually grasped these concepts on a day-to-day basis, they each began their quest to seek out the best sources of evidence and to implement them in a sustainable way. Each of them turned to the Registered Nurses' Association of Ontario (RNAO) to acquire Best Practice Guidelines (BPG) to understand how to implement and sustain them, and finally to position their organizations to become Best Practice Spotlight Organizations (BPSO). Each undertook a unique approach related to: their motivation to become a BPSO, getting started, successes, challenges, and overall organizational impact. In this chapter, each leader discusses this unique approach, what BPSO looks like in their organization today, and their perspectives on the future.

CASE STUDY

TORONTO PUBLIC HEALTH BPSO EXPERIENCE

Toronto Public Health (TPH) serves 2.8 million residents and employs 1,800 staff, including 750 nurses. TPH's mission is to reduce health inequities and improve the health of the whole population. Innovative programs, direct services, partnerships, health communication, health monitoring, and advocacy for healthy public policies help to prevent sickness and disease, promote health, and improve the quality of people's lives.

Population health aims to improve the health of the entire population and is the primary approach in public health work. Its programs, services, and health policies focus on responding to the needs of vulnerable populations and advocating for attention to social determinants of health (Public Health Agency of Canada [PHAC], 2012).

LEARNING FROM THE PAST

In late 2002, a previously unknown disease emerged from China called severe acute respiratory syndrome, or SARS, spreading across the globe over the course of several weeks (Health Canada, 2003). About 8,500 persons worldwide were diagnosed with probable SARS during the epidemic, and there were over 900 deaths (Health Canada, 2003). Toronto was the epicenter for the SARS epidemic, which placed unprecedented demands on the public health system, challenging capacity for outbreak containment, surveillance, information management, and infection control. In the years following, the response was analyzed revealing systemic deficiencies in the public health system in Canada. We learned that Canada's ability to fight an outbreak such as SARS was tied more closely to the specific strengths of the public health system than to the general capacity of our publicly-funded healthcare system (Health Canada, 2003). A strong national call to improve public health services resulted.

System change included a new *Ontario Agency for Health Protection and Promotion* and revised *Ontario Public Health Standards* (Ministry of Health and Long-Term Care[MOHLTC], 2008), which established minimum requirements for fundamental public health programs and services. Both the new agency and standards would build an evidence-based culture for public health practice in Ontario. Instead of planning programs and services in response to public demand or spotty use of evidence, all public health programs and services would be based on evidence. Further, a "capacity review" of the public health system called for increased public accountability including evidence-based programming and performance monitoring and reporting (Capacity Review Committee, 2006).

Key to the recommendations following SARS was a plan to rebuild the public health workforce with a range of activities from defining competencies through introduction of master's programs and professional development for staff (Joint Task Group on Public Health Human Resources, 2005). Advancing practice would require integration of evidence.

BPSO AND TPH: PERFECT ALIGNMENT

This increased focus on evidence, accountability requirements, and human resource recommendations post-SARS was aligned with internal directions at Toronto Public Health (TPH). With a strategic orientation toward innovative and outstanding service, a new professional practice model was being developed to enable the highest quality of professional practice. This mechanism would enhance the development of professional nursing leadership in the organization, facilitating the creation of mechanisms to support excellence in nursing practice, a catalyst toward TPH becoming part of the RNAO BPSO initiative. BPGs, with practice recommendations based on current and quality research, ensured the evidence was available. BPSO made integration of the evidence possible.

TPH staff had been involved in the development and integration of many RNAO Best Practice Guidelines (BPG) in the past, paving the way toward exploration of the merits of becoming a BPSO. A readiness assessment by nursing leaders found willingness and opportunity to improve evidence-based service and determined TPH was ideally situated to become a BPSO to positively impact evidence-based practice. An initial gap analysis (RNAO, 2012c) identified four BPGs to implement throughout the organization.

Fostering the development of others and building teams to encourage collaboration and cooperation are recognized as key to achieving results (Community Health Nurses of Canada, 2015). The initiative would need the buy-in of the senior management and practice support networks. A TPH BPSO structure was established to enable collaboration and support. The structure was designed to consist of a central steering committee as well as BPG implementation teams, each supported by Champions.

The steering committee is composed of one member from each of the BPG teams (currently 12) and is connected to the chief nursing officer and medical officer of health as well as professional practice supports (see Figure 8.1).

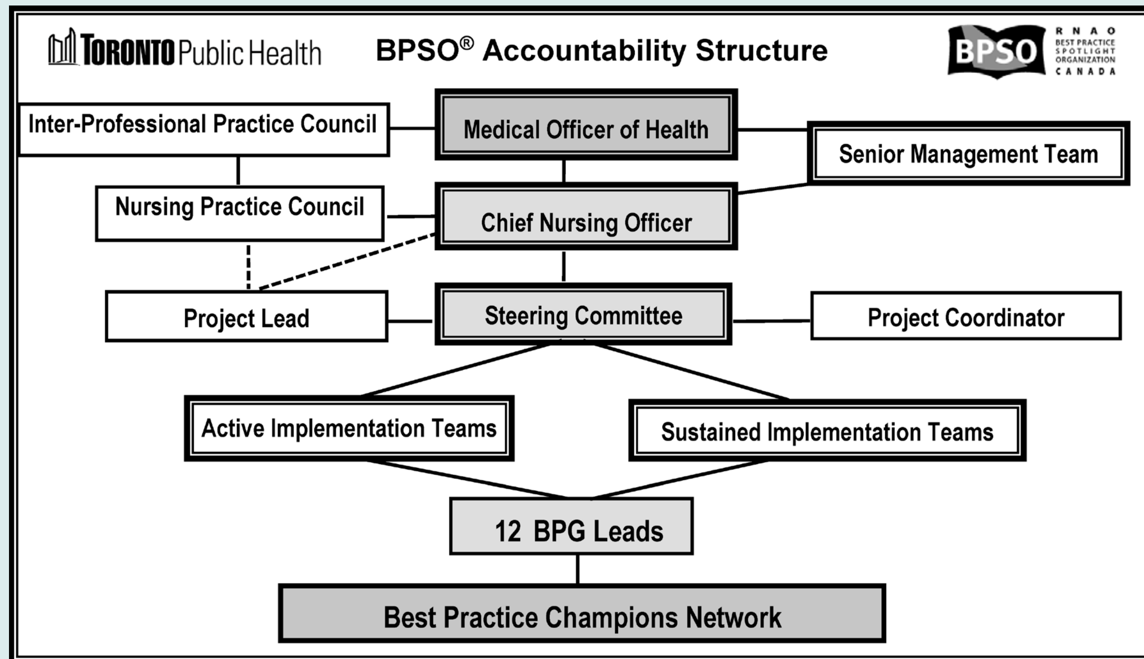

FIGURE 8.1 TPH BPSO accountability structure.
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Each BPG team works to initiate, implement, and evaluate recommendations from its guideline and has a cadre of Champions to work with from across the organization.

The Champion model is well established in the literature as an effective method of knowledge transfer (Flodgren et al., 2011; Kitson, 2009; Ploeg et al., 2010). An enthusiastic and committed group of over 260 BPG Champions has been recruited from several program areas and disciplines to assist with implementation. Champions are assigned to specific BPG implementation and evaluation activities based on skill sets and relevance to programs. An orientation webinar, tailored to public health practice, is provided to new Champions, enabling them to understand the overall BPSO initiative and the role and significance of being a Champion. The primary responsibility of Champions is to be a resource for their colleagues as an "expert" about their BPG. Champions post signage at their workstations, so colleagues are aware they are Champions and can seek them out as necessary (see Figure 8.2).

FIGURE 8.2 Champion desk sign.
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Champions are provided with ongoing professional development and support and, in turn, they provide training and support to their colleagues. One innovative strategy was training Champions in storytelling as an additional knowledge-transfer tool. Champions proved to be competent and knowledgeable public health practitioners who quickly shifted to evidence-based practice, contributing to excellence in public health. The Champion role is an excellent opportunity to develop leadership capacity.

COLLABORATION FOR SUCCESS

Although BPSO was initiated by nursing at TPH, its implementation is interdisciplinary and across the organization. Collaboration between professionals in a variety of program areas and with external partners has enhanced a systematic integration of evidence. Examples include the *Primary Prevention of Childhood Obesity* BPG team and the *Integrating Smoking Cessation into Daily Practice* BPG team.

The *Primary Prevention of Childhood Obesity* (RNAO, 2014c) BPG team has over 100 Champions who implement and evaluate the guideline. Public Health Nurses (PHNs) and Registered Dieticians collaborate to build capacity with schools in addressing strategies to reduce childhood obesity in 18 (and counting) Toronto schools. Nurses from the *Integrating Smoking Cessation into Daily Practice* (RNAO, 2003c) BPG team work with staff from across the organization to provide cessation counselling and nicotine replacement therapy to Toronto residents who would not otherwise have access to this evidence-based cessation tool. Partnership with other smoking cessation stakeholders has enabled sustained support for clients starting a quit attempt.

CUSTOMIZED SOLUTIONS TO FIT THE PRACTICE CONTEXT

The BPSO Initiative is part of a bigger picture to systematically integrate evidence into practice. TPH's unique role in health promotion in a population health context sometimes requires adaptation of BPG content to fit the public health context. The *Woman Abuse: Screening, Identification and Initial Response* BPG (RNAO, 2005f), for example, suggests universal screening "each time the health history is updated" (p.23), which is not appropriate for TPH group programs where clients attend multiple sessions. Occasionally at the adaptation stage, there is a need to conduct further research or literature reviews to ensure a fit with the strong prevention and health promotion philosophy in public health. The *Preventing and Addressing Abuse and Neglect of Older Adults* (RNAO, 2014b) BPG team completed a literature review to further define elder abuse prevention and to adapt strategies to fit the public health practice context.

START SMALL, THINK BIG

Best Practice Guideline recommendations are piloted in a small program team first and then evaluated (start small). Once the intervention's effectiveness is demonstrated, the intervention is scaled up to other programs and teams in the organization. Results are often disseminated internally at knowledge translation events and externally through publications and conferences (think and act BIG), contributing to systematic integration of evidence into practice. All levels of the organization are involved, from the Board of Health to the direct-care staff, to enhance practice and sustain the change.

CHALLENGES

During TPH's first year of BPSO candidacy, the organization experienced infrastructure challenges, taxing the staff and senior management (a 6-week labour disruption, and a level 5 H1N1 pandemic). These unforeseen challenges delayed the rollout of the BPSO events, necessitating compression of candidacy activities the following year. Managing the BPSO Designation required orienting new staff to assist and keeping a sharp focus on the work plan. TPH successfully moved forward and achieved designation in the required 3-year timeframe.

Evaluation of BPG implementation in public health practice can be a challenge. Measuring the success of implementation depends on the identification of measurable outcome indicators. Health outcomes for clients receiving public health intervention will often not be measurable until years after the intervention (e.g., increased rates of smoking cessation resulting in decreased rates of lung cancer). BPG teams have acknowledged this and are evaluating intermediate outcomes such as changes in client behaviour or awareness as well as outcomes related to staff learning and behaviour.

A TRANSFORMATIVE EXPERIENCE

The BPSO experience at Toronto Public Health has been transformative. It has increased our commitment to evidence-based practice and increased our staff competence, as well as their confidence that they are using the very best evidence available and making a measurable difference in the quality of service our clients receive.

A comprehensive evaluation conducted by TPH demonstrated that the experience of being a BPSO Designate has had positive benefits, including an increase in the use of evidence and knowledge sharing and increased collaboration amongst programs and interdisciplinary staff. Staff engagement in BPSO at all levels has contributed to organizational success in BPG implementation and sustainability (Toronto Public Health, 2011).

Toronto Public Health, the largest health unit in Canada, plays a leadership role for other public health organizations. As a BPSO, TPH soundly demonstrates the impact of creating and sustaining an evidence-based culture. Through full engagement and mobilization of the interprofessional team, sustained use of evidence-informed practice has made a difference in the health of the population in the City of Toronto.

CASE STUDY

BLUEWATER HEALTH BPSO EXPERIENCE

Bluewater Health—with locations in Sarnia and Petrolia, Ontario, Canada—is a fully accredited, 326-bed community hospital. With close to 2,500 staff, professional staff, and volunteers, Bluewater Health provides an array of specialized acute care, complex continuing care, allied health, and ambulatory care services. State-of-the-art facilities contribute to Bluewater Health's Mission: We create exemplary healthcare experiences with patients and families every time.

BLUEWATER'S MOTIVATION TO BECOME A BPSO

In 2009 and 2010, clinical practice professionals at Bluewater Health (BWH) were reviewing processes and procedures, seeking the evidence and rationale behind them in preparation for the move to a new hospital site in Sarnia. We recognized that some were based on habit and the practicality of locations of equipment, departments, and sites. The evidence required to ensure we were using current best practices and maximizing the opportunity to work collaboratively in the new environment was found in the RNAO's Best Practice Guidelines (BPG).

In October 2011, we submitted our proposal to RNAO to become a candidate to achieve BPSO Designation. Our quest began when the various professions engaged in focus groups to choose 7 BPGs for implementation, out of the possible 31 RNAO BPGs, that applied to our setting. Our selections were:

- *Client Centred Care* (RNAO, 2002a)
- *Supporting and Strengthening Families through Expected and Unexpected Life Events* (RNAO, 2002f)
- *Establishing Therapeutic Relationships* (RNAO, 2002c)
- *Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients* (RNAO, 2010e)
- *Integrating Smoking Cessation into Daily Nursing Practice* (RNAO, 2003c)
- *Assessment and Management of Pain* (RNAO, 2009a)
- *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2002d)

GETTING STARTED

We launched our BPSO journey in April 2012. Year one focused on the recruitment of 98 Best Practice Champions to lead the work. We developed structures and processes to support implementation and evaluation of recommendations, and our Interprofessional Champion Model promoted a collaborative approach to both practice and patient- and family-centered care (RNAO, 2002a, 2009b).

Our intention was to begin with the *Client Centred Care* BPG (RNAO, 2002a). It was immediately evident that the work associated with the implementation of the *Client Centred Care* (RNAO, 2002a), *Supporting and Strengthening Families through Expected and Unexpected Life Events* (RNAO, 2002f), and *Establishing Therapeutic Relationships* (RNAO, 2002c) guidelines was so aligned and integrated that we moved forward with all three together. They became known as the "big three." Best Practice Champions led the spread of the "big three" on each of their units, with peer-to-peer learning, leadership support, and engagement (RNAO, 2007, 2013b, 2016b).

TWO NOTEWORTHY SUCCESSES

The BPSO journey was hard-wired into the Mission Statement, Strategic Plan, and Performance Goals. During Strategic Planning (fall 2012), there was a desire to "hardwire" our care philosophy into quality and safety initiatives. Dialogue began with Standing Committees of the Board to articulate themes and goals. The process was inclusive, innovative, and warm. We brought ideas through our stories. There was energy from the bedside to the boardroom about what authentic patient- and family-centered care (PFCC) would mean to care providers and to the way we partner with patients and families in care. This resulted in the 2013–2015 Strategic Goal, "Embed Patient & Family-Centred Care," and the creation of supporting "We will" statements:

We will:

- Create a patient- and family-centered care strategy and action plan
- Establish a Patient Experience Partner Council and a PFCC Advisory Council
- Engage Patient Experience Partners (PEPs) in quality-improvement initiatives
- Develop a plan to educate our people on PFCC principles and care strategies
- Implement the RNAO BPGs—*Client Centred Care* (RNAO, 2002a), *Establishing Therapeutic Relationships* (RNAO, 2002c), and *Supporting and Strengthening Families in Expected and Unexpected Life Events* (RNAO 2002f)

We introduced Emily. Following broad consultation and site visits to exemplars in client-centered care, we began to explore the notion of naming *our patient,* as a way to really embrace client- and family-centered care (Toussaint, Gerard, & Adams, 2010). After much discussion of our findings and full engagement of staff through storytelling, we made the decision to name our patient. The name Emily was chosen, and each of us had an influence on Emily's experience of care, regardless of role. Emily came to represent every patient and family we had

cared for in the past, were currently caring for, and would care for in the future (Jennings, O'Neil, Bossy, Dodman, & Campbell, 2016)

Emily debuted at the 2013 launch of our Strategic Plan as a collage of images of all of us—patients and families, care providers, physicians, support service staff, students, volunteers—engaged in giving and receiving care. Emily represented every face amongst us. Staff, physicians, and volunteers can find themselves in the Emily image (see Figure 8.3). The picture was present for events including BPG launches and knowledge exchange events. A newsletter was developed, and direct-care leaders named it "Dear Emily."

FIGURE 8.3 Emily image.
Used with permission.

Our Patient Advocate engaged patients and family members to create the Patient Advisory Council. A new volunteer role, the Patient Experience Partner (PEP), was launched. One of our PEPs shared her reaction to the Strategic Plan: "Emily's symbolic presence is our inspiration. She is the reason we do what we do."

TWO NOTEWORTHY CHALLENGES

Implementation barrier: We do that already. The implementation of the "big three" required us to reflect on every activity surrounding care. In early discussions with providers, we heard, "We do that already." Movement forward required imagining what inclusivity in care could look like when we intentionally asked ourselves about

opportunities to invite patients and families into care as equal partners at point of care, on our units, and on our committees, including the Quality Committee of the Board for discussion about adverse events. We encountered scepticism, reluctance, and eventually a willingness to begin.

Courage required. It took courage to unveil the image of Emily and to explain this abstract notion. There was anxiety that the idea could be seen as "fluff," with the risk that the initiatives surrounding it, including the Strategic Plan and the journey to become a BPSO, could be tainted and our initiatives derailed. The courage and energy came from knowing that, regardless of role, whether in clinical, support, or administrative services, each of us could relate to Emily when we opened our hearts to the idea. We, or someone in our family, may have *been* Emily. If any one of us could be Emily, then how we deliver care becomes personal. Emily has brought focus to our conversations, our initiatives, our attitudes, our environment, and our culture.

OVERALL ORGANIZATIONAL IMPACT OF BPSO AND THE EMILY EFFECT

Over the course of our BPSO journey, we saw positive results in employee engagement scores and patient satisfaction scores. Comparing 2011 engagement scores with 2013, we achieved a 16% improvement in Quality Care; 19% improvement in Involvement in Decisions; and a 20% improvement in Positive Work Environment. Our overall employee-engagement score was 6% higher than other hospitals in Ontario.

When 2,500 staff, physicians, and volunteers began to think differently about Emily and to see the benefits of the "big three" BPGs on our culture, they experienced, in varying degrees, the meaningfulness of what we can do collectively. Emily has given the BPGs a face, a voice, and a realization that quality care based in evidence really does matter. As Champions made the alignment with all of the BPGs, they made the connections to Emily. Conversations and stories about Emily are increasingly shared across the organization. BPSO Initiatives implemented have taken on a higher relevance as Emily has provided us with a shared vision of what the patient experience and our culture can be. We received our Best Practice Spotlight Organization Designation in June 2015.

Also in 2015, the National Research Corporation, Picker Institute confirmed that our performance indicators on the Canadian Patient Satisfaction survey documents in several areas were above average and that they "were coming to visit BWH to see what we were doing." The Picker Institute was mapping patient-centered-care best practices, processes, and cultural attributes of the 99th percentile performers from publicly reported standardized patient experience data sets in Canada, Europe, and the U.S. BWH had achieved top performance in multiple dimensions of patient-centered care in comparison to other hospitals reporting in Ontario, with improvement in Access to Care, Physical Comfort, Respect for Patient Preference, Continuity and Transition, Coordination of Care, and Overall Rating scores. They wrote a case study profiling Bluewater Health as a high performer in delivering client-centered care based on exemplary performance on the acute care dimension of Access to Care (National Research Corporation, 2015).

SUSTAINING AND EXPANDING

Nearing the conclusion of the 2013–2015 Strategic Plan and with the achievement of our stated goals, there was a desire to take the "We will" commitments and refine them into statements that held specific and measurable relevance for each of us. Fourteen focus groups were held with 100 individuals from diverse roles including nurses, physicians, allied health professionals, management, support staff, patients, volunteers, PEPs, and family members. They were asked to recall moments of exemplary care. Together they drafted the "I will" statements that are called "My Promise to Emily" (Ontario Hospital Association, n.d.).

I promise you and your family I will:

- Respect you as an individual on a unique healthcare journey
- Take time to address your concerns and calm your fears
- Involve you whenever decisions are being made about you
- Be your advocate

Bluewater Health wrote the Mission Statement: "We create exemplary healthcare experiences *for* patients

and families every time," about 8 years ago. It guided us beautifully for many years. As we introduced Emily, we began to question the appropriateness of the word *for.* We wondered if we had moved so far as to change the word to *with.* After receiving our BPSO Designation, we began the work of the Strategic Plan 2016–2021. The new plan is called "Kaleidoscope of Care." The image of Emily is at the center. At the board retreat, spring 2016, it was decided that the Mission Statement would officially be changed to, "We create exemplary healthcare experiences *with* patients and families every time."

Becoming a BPSO has given us renewed energy. Creating a culture where this kind of caring can occur is perhaps the greatest effect of Emily to date. Many of our staff spoke about BPSO and Emily at events in Canada and the United States in order to share our successes and challenges and be a mentor and role model for others. The philosophy of evidence-based patient- and family-centered care that we desired 8 years ago is now hard-wired into our mission statement and our culture, where we have re-engaged with the human experience of caring.

CASE STUDY

NORTH BAY NURSE PRACTITIONER-LED CLINIC BPSO EXPERIENCE

The North Bay Nurse Practitioner-Led Clinic (NBNPLC) is one of 25 Nurse Practitioner-Led Clinics in Ontario, Canada. Nurse Practitioner-Led Clinics are an innovative model for delivery of comprehensive primary healthcare in Ontario, Canada, that are "led" by nurse practitioners at a governance and administrative level. The NBNPLC opened its doors in the Nipissing District in northern Ontario in 2011 to help meet the demand of people seeking primary care. Clinic staff, including nurse practitioners, registered nurses, and social workers, work to their full scope of practice as defined by the regulatory colleges.

IN THE BEGINNING

In 2011, as a new organization with healthcare providers coming together from all areas of the health system, the NBNPLC was challenged to incorporate evidence-based procedures into the process of providing primary care. The team set a goal to define what processes could be performed similarly by all members of the healthcare team, based on the best available evidence, while maintaining the priority of patient-centeredness in a relationship-based model of healthcare.

The team developed the following goals to guide all care and service provided at the clinic.

- Provide safe, ethical care with prevention as a key outcome for patient care
- Base delivery of care on the best available scientific knowledge to all those who could benefit, and refrain from providing interventions when evidence suggests otherwise (Choosing Wisely Canada, n.d.)
- Avoid waste and find ways to improve processes based on Lean implementation (Toussaint et al., 2010)
- Intake patients who are underserved and need primary care, while at the same time implementing same-day access to appointments
- Provide equitable care that does not vary in quality based on gender, ethnicity, income, sexual orientation, or religion
- Provide care that is respectful and responsive to patient needs, values, and preferences

In order to help ourselves achieve these goals, we applied to RNAO to become a BPSO, with the successful outcome of achieving BPSO Designate status. Central to its success, the whole clinic (14 staff) became involved in implementation of five clinical BPGs, namely: *Integrating Smoking Cessation into Daily Practice* (RNAO, 2003c), *Assessment and Management of Pain* (RNAO, 2009a), *Interventions for Postpartum Depression* (RNAO, 2005c), *Woman Abuse: Screening, Identification and Initial*

Response (RNAO, 2005f), *Strategies to Support Self-Management of Chronic Conditions* (RNAO, 2010e); and one HWE BPG—*Collaborative Practice Among Nursing Teams* (RNAO, 2006). When working with the RNAO BPGs, because this was an interprofessional initiative, the NBN-PLC team made an intentional decision to use terms that were inclusive of all healthcare professionals. Over the 3 years of BPSO candidacy, six workgroups were formed, with a lead who organized and facilitated meetings with those who self-identified as wanting to work on BPG implementation in the clinic. In 2015–2016, as a BPSO Designate, the clinic implemented two more clinical BPGs, namely *Breastfeeding Best Practice Guidelines for Nurses* (RNAO, 2003a) and *Nursing Management of Hypertension* (RNAO, 2005d).

System-wide implementation meant that all staff working at the clinic were involved in all aspects of BPG uptake, including prioritizing which BPGs to implement first and using the RNAO BPG Toolkit (RNAO, 2012c) to ensure a systematic methodology. For example, many staff were familiar with the *Integration of Smoking Cessation into Daily Practice* BPG (RNAO, 2003c), and one of the nurse practitioners was already a smoking cessation BPG Champion, so that BPG was identified as our first priority.

All BPGs were chosen based on the issues identified in the patient population we serve, as well as available practice Champions and available local resources. Because of the targeted support from RNAO that was provided over the 3 years pre-Designation, all staff became BPG Champions, and each took on various lead positions for one of the six BPG workgroups.

Results of work by the individual groups were shared with the clinic team at bimonthly BPG meetings. Process maps, standardized documentation procedures, and coding in the Electronic Health Record (called Nightingale) helped communicate and sustain practice changes. Various reporting formats were created along the way, including a BPG Dashboard (see Figure 8.4). The segment of the dashboard included in the figure demonstrates, in the graph on the left side, the number of patients screened preimplementation of the RNAO Pain BPG (RNAO, 2009a), and, in the graph on the right side, the number of patients screened post-implementation. The differences are striking, and they have consistently grown and been sustained. NQuIRE was also utilized to track structural, process, and outcome measures, in relation to this and other guidelines.

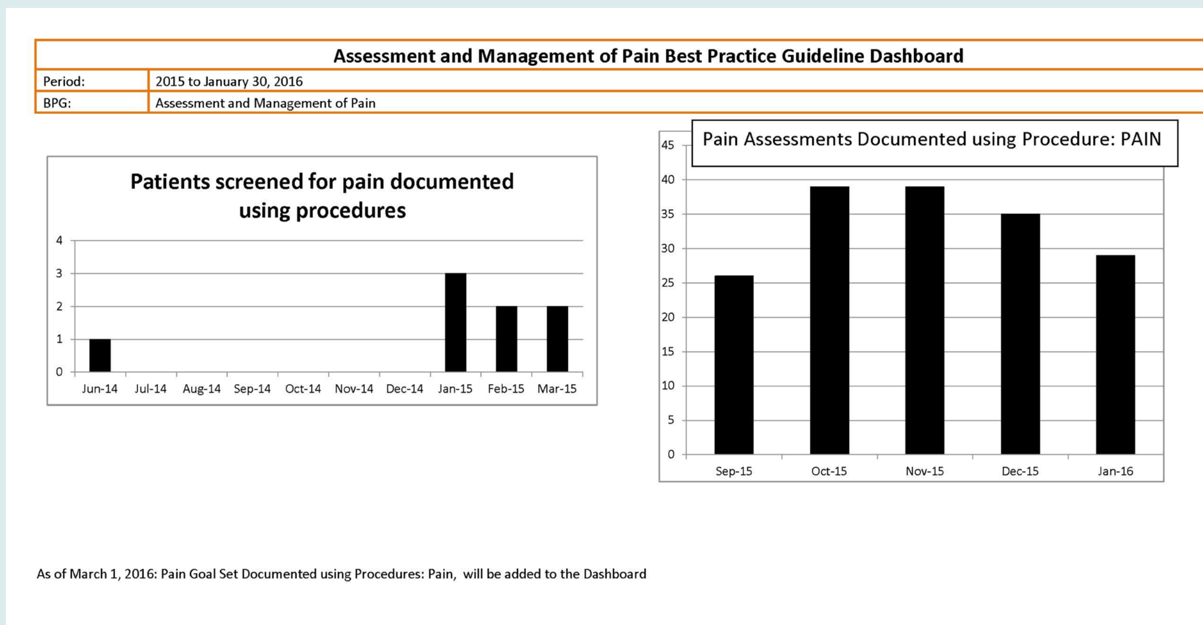

FIGURE 8.4 Dashboard showing patients screened for pain documented using procedures, before and after implementation of the *Assessment and Management of Pain* BPG (2009a). Used with permission.

STAKEHOLDER INVOLVEMENT IS KEY

Stakeholders were involved throughout our BPG journey and continue to be utilized based on their mandates, interest, time availability, and influence. The model for stakeholder participation that guided us suggests at least four different ways people and agencies can support a cause (Ontario Agency for Health Protection and Promotion [Public Health Ontario], 2015). These include:

1. As part of the "Core"
2. "Involved" in the work
3. "Supportive" of the cause
4. "Informed"

Using this model, it was identified that stakeholder support did not always require attending meetings or being part of the "core" group.

Attention to stakeholder involvement desired by the "core" group ensured a good match between stakeholders and the goals for the project, such that they could be involved in ways that were consistent with what they could contribute. This also enabled new stakeholders to emerge over time. An example was our partnership with the North Bay-Parry Sound District Health Unit, which was engaged as a "supportive" stakeholder for many of the BPGs implemented and continues to support us when there is a "fit."

As our work progressed and became more public and our stakeholder circle expanded, not only were we called on locally as leaders of best practices, but provincially as well. Our processes were distributed to the Ontario Nurse Practitioner-Led Clinic Network for use by others. An example of this was with the *Assessment and Management of Pain* BPG (RNAO, 2009a), which was adapted to be consistent with the change to scope of practice for nurse practitioners in the spring of 2017 (College of Nurses of Ontario, 2017). Process maps and tools were distributed upon request to other Nurse Practitioner-Led Clinics (see Figure 8.5).

Another successful strategy for implementation was the engagement of BScN students from Nipissing University. Nursing students participated over a semester with clinic staff and patients on the *Strategies to Support Self-Management of Chronic Conditions: Collaboration with Clients* BPG (RNAO, 2010e) to create educational resources for patients. These students collaborated with patients to establish goals and develop action plans as directed through the BPG recommendations. The client-driven action plans were actively utilized in guiding self-care and were monitored by students, patients, and staff throughout the semester, with documentation of progress.

A key lesson from our BPSO journey was that the implementation of innovations can radically affect professionals' daily work processes and requires considerable time and willingness to learn. The adoption of new ways of practice implies an interruption of past-learned behaviours on the part of practitioners. Also, the BPSO journey has created a paradigm shift in control and power out of the hands of providers and into the hands of those who receive care. In 2018, we cannot regard patients as passive, but rather as equal, participatory partners who contribute to their own healthcare. The guidelines are congruent with this change and encourage the use of motivational interviewing and mutual goal setting. Combine this with scope-of-practice changes (such as the ability of nurse practitioners to prescribe narcotics and benzodiazepines in 2018), and the environment is both exhilarating and challenging. This quote by one of our nurse practitioners reinforces the feelings of our staff, fully engaged in our BPSO adventure:

> *"Through the BPSO Designation work at NBNPLC, I gained new knowledge and clarified my role as a nurse practitioner and a knowledge professional. It reinforced that I want to belong to and contribute to a culture of best practice. Know better, do better."*
>
> –Terri MacDougall, Nurse Practitioner (NP)

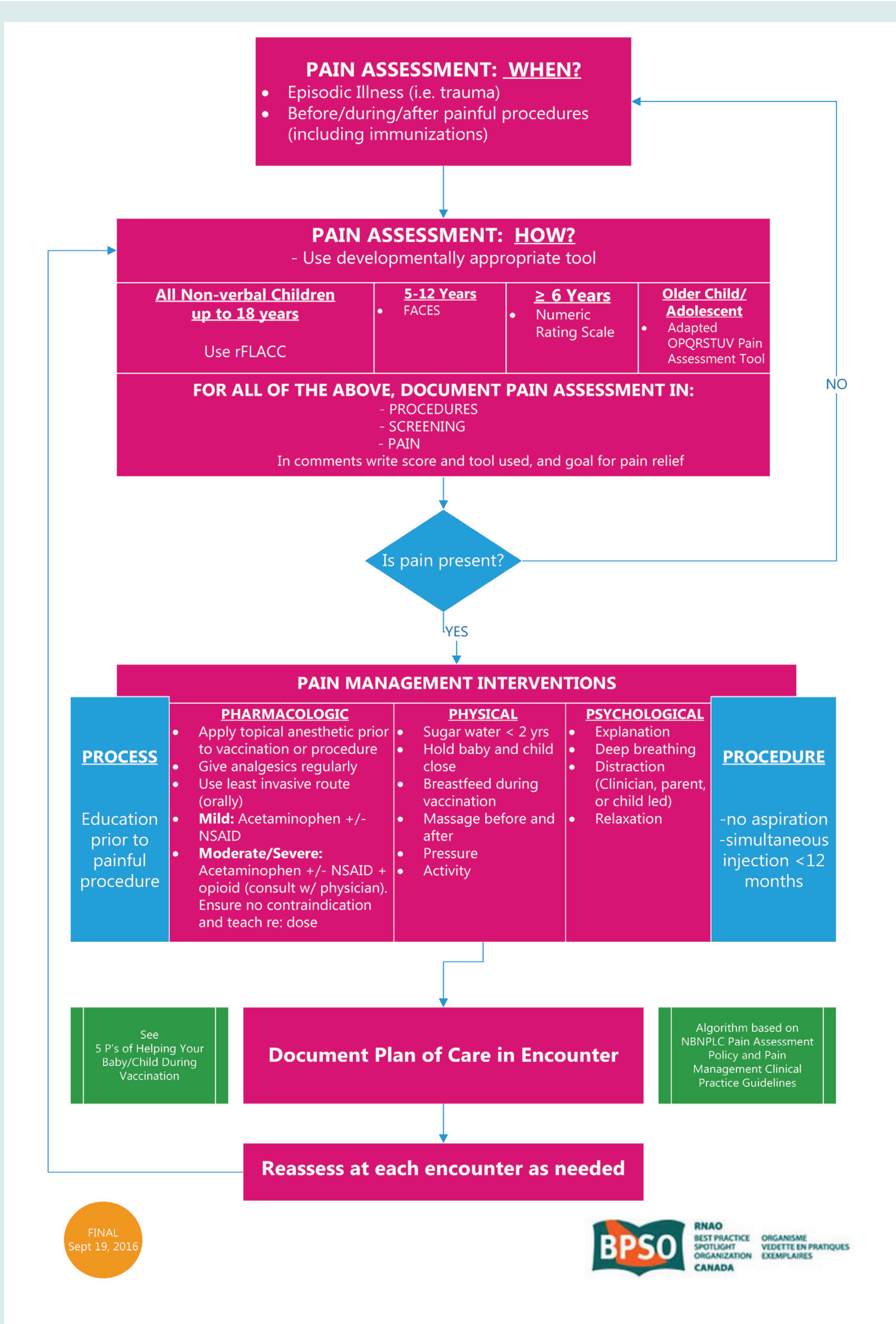

FIGURE 8.5 Protocol for pain assessment and management of the child. Used with permission.

The challenges of taking the time to truly ascertain patients' concerns and needs—as well as pay attention to documentation and data collection requirements—are real issues (Young, Roberts, & Holden, 2017). These are issues we have to be mindful about as we maintain a client- and family-centered approach within our context of evidence-based practice and a focus on quality care and outcomes.

LEADERSHIP AS KEY TO SUCCESS

Managerial leadership by both the executive director, as a registered nurse, and the clinical director, as a nurse practitioner, provided encouragement and allowed time for staff to work on implementation tools and report back at meetings. Both leaders role-modeled a creative, adaptive, and supportive approach, and implementation of BPGs became part of the culture of evidence-based practice at the NBNPLC.

GREATEST CHALLENGE

One of the greatest challenges along the way was of staffing changes. However, with RNAO's support we focused on development of Champions, learned from our work at regular BPG update meetings, and developed and used BPG-related clinical decision supports for assessment, intervention, and documentation. All of these activities helped us keep up the momentum and continually improve.

SUSTAINABILITY FOR A SMALL TEAM

Early in our implementation phase, members of the NBNPLC team used the National Health System (NHS) Institute for Innovation and Improvement Sustainability Model (Maher, Gustafson, & Evans, 2010) to determine how best to sustain the work and current and future achievements. The Sustainability Model is a diagnostic tool that is used to predict the likelihood of sustainability for an improvement initiative. Areas of strength to support the BPSO work and outcomes identified by our team included: fit with organization's strategic aims and culture; clinical leadership engagement; staff behaviours toward sustaining the change; staff involvement and training to sustain the process; effectiveness of the system to monitor progress; and credibility of the evidence. The areas of improvement included: infrastructure for sustainability; senior leadership engagement; adaptability of improved processes; and benefits beyond helping our patients. An action plan was created that included sustaining our journey forward as we continue with implementation in the years to come.

Our journey as an RNAO BPSO and our continuous reflection on our efforts has enabled us to systematically implement and sustain new best practices and measure their impact. Providing timely data to the BPG-focused NQuIRE database system to assess progress has prompted an outcomes orientation and created a culture of enduring evidence-based practice, leading to better health outcomes for our clients.

CASE STUDY

BAYSHORE HEALTHCARE LTD. BPSO EXPERIENCE

Bayshore HealthCare is one of the country's leading providers of home and community healthcare services and a Canadian-owned company. Its services are purchased by government care programs, insurance companies, workers' compensation boards, healthcare organizations, the corporate sector, and the public. We serve Canadians coast to coast through over 60 branch offices and over 100 community clinics, and we employ approximately 12,000 full-time or part-time staff, including over 4,000 registered nurses as well as occupational health and safety specialists, occupational therapists, physiotherapists, speech and language rehab, social workers, dieticians, pharmacists, pharmacy technicians, physicians, dentists, personal support workers, and other unregulated care providers.

MOTIVATION TO BECOME A BPSO

Creating an evidence-based culture at Bayshore and subsequent application to be a BPSO was initiated by our clinical leaders, who identified the need to refocus the way we made organizational choices. The vision involved moving from task-based work to achieving clinical outcomes and would infiltrate through all levels of decision-making including strategic planning processes, informing evidence-based care planning, and ensuring the delivery of the best-quality home healthcare. Operational leadership agreed. That led to participation in the rigorous RNAO BPSO application process, following which, in 2012, Bayshore was selected to become a national Best Practice Spotlight Organization.

Our goal was to provide sustainable, superior, and trusted service to our clients and customers, and our objectives were to support ongoing improvement in our programs, clinical leadership capacity, and research opportunities. This fit well with our organizational objectives to create a great employee experience throughout the career journey and a care experience at Bayshore that ensures an enduring relationship with the client and family during the care processes.

One of the initial steps was creating a strong clinical quality accountability framework, followed by building an infrastructure and identifying necessary resources to support it. A specialized team of prepared clinicians would be instrumental in driving change in clinical and operational policies, processes, and systems. These team members were educated to be experts in promoting change at the clinician level through knowledge translation and guided workflows to drive informed decision-making at the front line.

HOW WE STARTED

Foundational to supporting system changes and creating robust electronic clinical management and learning systems was changing the culture at the front line to one of an evidence-based approach. Bayshore's vision statement embodies our commitment to client-centered care: "to enhance the quality of life, independence and dignity of Canadians in their homes," and our values capture our commitment to improvement in clinical capacity and nursing practice excellence. Our vision helped drive the cultural change needed.

At Bayshore, we knew that the best way to realize our vision was to provide the decision support tools, education, and coaching to our direct-care staff so that they could be prepared with the most relevant and up-to-date nursing knowledge, be secure in their work environment, and feel safe and supported by the organization.

The BPSO work has helped us to further reinforce our values in a demonstrable way and to further our mission to make a difference in our clients' lives. We understood that this would require commitment to embracing the culture of best practices in nursing; supporting and engaging nurses throughout our organization; and allocating resources to national, branch, and direct-care levels.

The BPSO Agreement outlined the scope for the project, and a steering committee was established to support leadership and decision-making. There were subcommittees developed at a working group level to take on specific aspects of work such as policy development. Capacity building was critical to create a long-term plan through an identified cohort of nurses. We engaged a critical

mass of nurses as BPG Champions to support guideline implementation and evaluation, and we created a network of BPG Champions across the entire organization in Canada. We worked with the RNAO BPSO Coach and other designated mentor organizations to develop guideline implementation capacity; we felt greatly supported in this work.

Cultural change was initiated through a core team of six RNAO eHealth Best Practice Champions who worked on our first BPG implementation back in 2006. They introduced the Healthy Work Environment BPGs, which guided us in the review and revision of many of our policies, including human resource, clinical, and operational policies, to set the stage for implementing clinical BPGs.

Data would drive our learning and our care. Metrics to track implementation and evaluation were included under the domains of nursing practice, clinical outcomes, and organizational structure. We were well positioned to participate in research projects, with our data being uploaded into the NQuIRE database. We created a bridge for data interface between our electronic clinical management systems and the RNAO NQuIRE system to support evidence to inform revisions to processes based on outcomes and BPG content.

BUILDING A CULTURE OF EVIDENCE-BASED PRACTICE

One of the greatest challenges in providing home care clinical services is the remote nature of work. Our nurses often have limited clinical history and background information about the clients and their current health status upon initiating care. Initially, with client consent, our home care nurse conducts a risk and hazard assessment that creates an understanding of each client's environmental context and identifies potential risks for each client as well as the care team. Examples of potential risks may include presence of scatter-mats that could be a fall hazard for the client, or dogs or guns that could be a hazard for the care team visiting the home.

Care at Bayshore has evolved significantly over the years since BPSO implementation, in transitioning from general assessment and care plan templates to algorithmic care pathways that guide clinicians to prepare evidence-based care plans. These pathways were based on RNAO's BPGs. The pathway-based approach was foundational to moving toward the eventual implementation of RNAO nursing order sets (NOS) for specific population-based care, which required a robust electronic clinical management information system.

Subsequently, during our BPSO candidacy period from 2012 to 2015, Bayshore was able to implement BPGs that were aligned with our strategic direction, including *Person-and Family-Centred Care* (RNAO, 2015); *Supporting and Strengthening Families Through Expected and Unexpected Events* (RNAO, 2002f); *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2002d); *Oral Health: Nursing Assessment and Interventio*n (RNAO, 2008a); and *Assessment and Management of Pain* (RNAO, 2009a). These BPGs were considered vital in providing client-focused care that was inclusive of family and caregivers. Our organization purposefully wanted to enhance support for unregulated care providers through the transfer of authority process, and for our clinicians providing care to our client population across all types of community care, and programs across Canada. We also chose BPGs to implement within clinical domains to strengthen our signature programs: Wound Care; Hospice Palliative Care; Paediatrics; and Frail Elderly. Following our BPSO Designation, we added BPGs including *Facilitating Client Centred Learning* (RNAO, 2012a) and *Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients* (RNAO, 2010e).

SUSTAINING THE CHANGES

Sustainability requires vigilance and continued investment as a BPSO, communicating what it stands for and keeping it at the front of Bayshore's thinking and philosophy. There has been a steady buy-in from clinicians across the organization. The challenge is keeping the focus on driving evidence-based care and more importantly keeping it relevant to what is impacting Bayshore and the home care sector. As our clinical practice leaders have recognized, all guidelines have to be considered in relation to the home care context, and the better we do this, the better the fit and potential for sustained use.

The development and deployment of Bayshore's Clinical Accountability Model has supported sustainability of BPG implementation. This approach is fundamental to achieving outcomes, working within integrated or bundled funding models (see Figure 8.6).

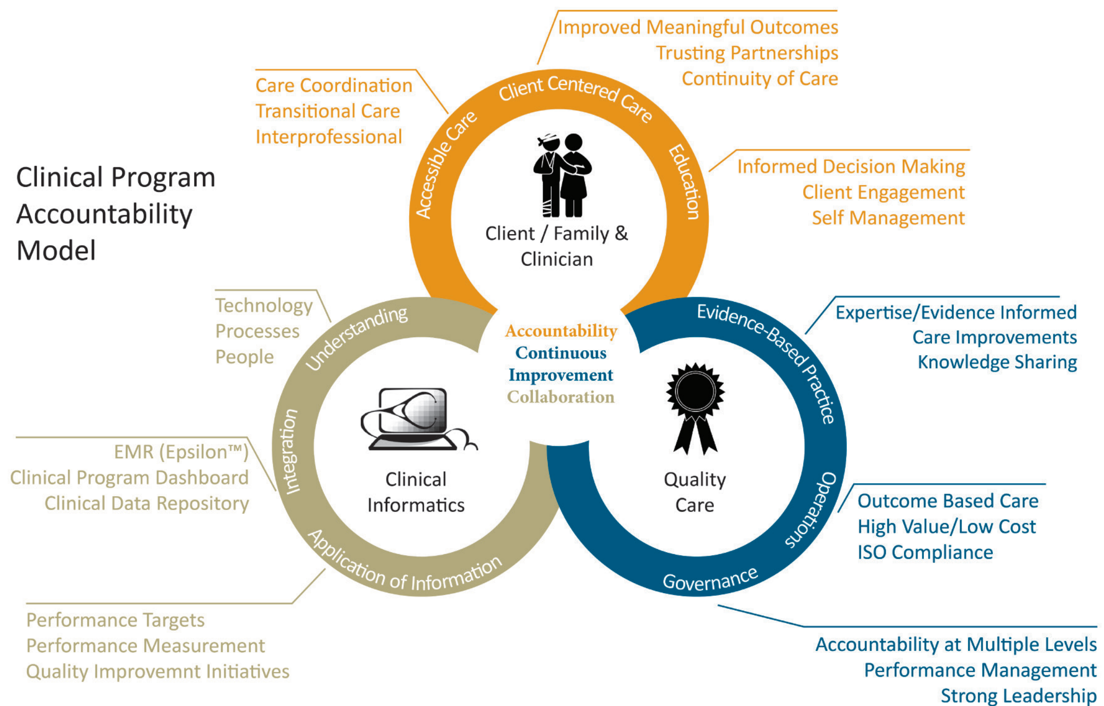

FIGURE 8.6 Bayshore's Clinical Accountability Model.
Used with permission.

SUCCESSES AND CHALLENGES AS A BPSO

As a BPSO, Bayshore was able to grow clinical leadership, and evidence-based clinical and management decision-making, through the candidacy and designation maintenance BPSO phases. Our structures and span of control were modified to create more effective and efficient service models based upon evidence. The successes from our investment in evidence-based practice through the BPSO Designation are that we:

- Influenced system changes to support evidence-based practice (e.g., funders' use of evidence in reporting requirements that are aligned with RNAO nursing order sets)
- Supported discussions with government funders to move from measuring only operational process indicators to clinical outcome indicators
- Increased our ability to build capacity as an organization through the implementation of the Healthy Work Environment BPGs, which addressed the challenge of managing change and transformation to sustain an evidence-based practice culture (*Developing and Sustaining Nursing Leadership* [RNAO, 2013c]; *Managing and Mitigating Conflict in Health-Care Teams* [RNAO, 2013d]; and *Intra-Professional Collaborative Practice Among Nurses* [RNAO, 2016b])
- Were able to deploy across all groups of care providers including registered nurses, unregulated caregivers, pharmacists, therapists, and nonclinical operational and business employees
- Successfully spread RNAO BPGs across the country
- Maximized impact as a knowledge organization through evidence-based practice, nursing order set use, and evaluation of data over time

We knew there were going to be possible barriers to implementing and sustaining our work. Risks were identified and quantified, and strategies were developed to respond. Some of the earliest challenges that were identified and mitigated included:

- Ongoing senior management support, not just commitment at start-up
- Lack of commitment to dedicated resources over time
- Failing to include all staff, including direct-care clinicians
- Not having systems in place to monitor outcomes
- Not having local clinical leaders and Champions at the point-of-client-care delivery

THE IMPACT ON BAYSHORE

We have worked with the RNAO BPSO Coaches, mentors, and BPSO Designates to implement BPGs to access existing expertise and to assist in quality-improvement outcome monitoring. This has been a strong partnership with over 5 years of investment in clinical leadership, systems development, and learning and knowledge frameworks that have transformed the organization to reflect a culture of evidence-based care.

Bayshore has been on a significant journey from implementing initial BPGs to leading the entire organization toward accountable, evidence-based care. Our clinical leadership and Champion network was foundational in our ability to embark on scalable programs across provinces and succeed in effecting change at the front line. This has supported our growth and positive working environment, enabling clinicians to thrive in their practice. Evidence is not only at our fingertips, but also actively used in practice, supported by leadership in all roles.

CASE STUDY

ST. MICHAEL'S HOSPITAL BPSO EXPERIENCE

St. Michael's Hospital (SMH) is a 459-bed, inner city, academic health sciences center fully affiliated with the University of Toronto. The hospital employs over 6,000 staff including 1,887 registered nurses and 52 nurse practitioners. The hospital provides tertiary and quaternary services in cardiovascular surgery, neurosurgery, inner city health, and therapeutic endoscopy. It is one of two Level 1 adult trauma centers in Greater Toronto. SMH was founded by the Sisters of Saint Joseph in 1892 with the mission of taking care of the sick and poor of Toronto's inner city.

EMBEDDING EVIDENCE-BASED PRACTICE INTO THE CULTURE

Our RNAO BPSO Designation journey enabled evidence-based practices to become embedded and sustained into the fabric of nursing practice at SMH. BPSO work is evident throughout the organization from our corporate communication and professional development offerings to corporate priority planning and direct-care activities. The transition from BPSO candidate to Designate was a smooth, seamless process due, in part, to the strong foundation laid during our candidacy work. Nursing has embraced the importance of evidence-based practices and has continued to engage in further BPG implementation, sustainability, and spread activities since BPSO Designation.

The BPSO Designation team now concentrates its efforts on developing and supporting corporate processes and structures to sustain, spread, and initiate BPG uptake. Since our quest for BPSO Designation began in 2009, we have successfully initiated 33 BPGs; of those, 6 have most recently been implemented, 13 have been initiated and sustained; and 14 have been sustained and spread to new areas. Approximately 30% of our staff from 37 different clinical care areas are recognized as BPG Champions based on their knowledge and leadership in BPG uptake. See Table 8.1 for a detailed list of BPGs that have been implemented at SMH.

TABLE 8.1 BPGS THAT HAVE BEEN IMPLEMENTED AT SMH, AND THEIR STATUS—IMPLEMENTED, SUSTAINED, OR SPREAD

NUMBER	RNAO BEST PRACTICE GUIDELINE	STATUS
	Establishing Therapeutic Relationships (RNAO, 2002c)	Spread
	Professionalism in Nursing (RNAO, 2007)	Spread
	Workplace Health, Safety, and Wellbeing of the Nurse (RNAO, 2008b)	Spread
	Crisis Intervention (RNAO, 2002b)	Spread
	Strengthening and Supporting Families Through Expected and Unexpected Events (RNAO, 2002f)	Spread
	Nursing Management of Hypertension (RNAO, 2005d)	Sustained
	Stroke Assessment Across the Continuum (RNAO, 2005e)	Sustained
	Developing and Sustaining Safe Effective Staffing and Workload Practices (RNAO, 2005b)	Sustained
	Integrating Smoking Cessation into Daily Nursing Practice (RNAO, 2003c)	Sustained
	Woman Abuse: Screening, Identification and Initial Response (RNAO, 2005f)	Spread
	Breastfeeding Best Practices Guidelines for Nurses (RNAO, 2003a)	Spread
	Embracing Cultural Diversity in Health Care: Developing Cultural Competence (RNAO, 2003b)	Spread
	Interventions for Post-Partum Depression (RNAO, 2005c)	Sustained
	Promotion of Continence Using Prompted Voiding (RNAO, 2002e)	Sustained
	Screening for Delirium, Dementia and Depression in Older Adults (RNAO, 2010d)	Spread
	Assessment and Management of Foot Ulcers for People with Diabetes (RNAO, 2013a)	Sustained
	Assessment and Device Selection for Vascular Access (RNAO, 2004)	Sustained
	Client Centred Care (RNAO, 2002a)	Spread
	Prevention of Falls and Fall Injuries in Older Adults (RNAO, 2002d)	Spread
	Caregiving Strategies for Older Adults with Delirium, Dementia and Depression (RNAO, 2010b)	Spread
	Risk Assessment and Prevention of Pressure Ulcers (RNAO, 2010c)	Sustained
	Promoting Safety: Alternative Approaches to the Use of Restraints (RNAO, 2012b)	Spread
	Preventing and Managing Violence in the Workplace (RNAO, 2009c)	Sustained

continues

TABLE 8.1 BPGS THAT HAVE BEEN IMPLEMENTED AT SMH, AND THEIR STATUS—IMPLEMENTED, SUSTAINED, OR SPREAD (CONTINUED)

NUMBER	RNAO BEST PRACTICE GUIDELINE	STATUS
	Assessment and Management of Pain (RNAO, 2009a)	Spread
	Care and Maintenance to Reduce Vascular Access Complications (RNAO, 2005a)	Sustained
	Strategies to Support Self-Management in Chronic Conditions (RNAO, 2010e)	Sustained
	Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour (RNAO, 2010a)	Sustained
	Preventing and Mitigating Nurse Fatigue in Health Care (RNAO, 2011b)	Implemented
	Developing and Sustaining Interprofessional Health Care (RNAO, 2009b)	Implemented
	Care Transitions (RNAO, 2014a)	Implemented
	Delirium, Dementia and Depression in Older Adults: Assessment and Care (RNAO, 2016a)	Implemented
	Person-and Family-Centred Care (RNAO, 2015)	Implemented
	End-of-Life Care During the Last Days and Hours (RNAO, 2011a)	Implemented

Embedding evidence-based practice into our culture and daily work processes is a result of six collective strategic efforts, including:

1. Aligning BPSO work with organizational strategic objectives and priorities
2. Evolving governance structures, infrastructure, and mechanisms
3. Communicating updates and sharing achievements
4. Evaluating our impact
5. Spreading and sustaining BPGs
6. Leveraging external funding and partnership opportunities

ALIGNING BPSO WORK WITH ORGANIZATIONAL STRATEGIC OBJECTIVES AND PRIORITIES

BPG implementation is purposefully aligned with the SMH strategic objectives and priorities. During our initial candidacy period, the BPSO deliverables were embedded in the annual corporate goals and objectives. Since that time, ongoing BPSO implementation and evaluation work has been aligned not only with our corporate strategic objectives and priorities, but further aligned with the Corporate Strategic, Quality Improvement, and Interprofessional Strategic Plans and the Senior Friendly Hospital Initiative.

Quality patient care has always been a priority for nursing at SMH; however, the RNAO BPSO Designation created an opportunity to be explicit in communicating that nursing's priority at SMH was to provide consistent,

quality patient care through evidence-based knowledge. Supported by nursing leadership, nurses identified BPGs that they believed would best address potential gaps in quality care on their local units. The BPSO Steering Committee recommended three foundational corporate BPGs that all clinical units would implement. These were: 1) *Establishing Therapeutic Relationships* (RNAO, 2002c); 2) *Professionalism in Nursing* (RNAO, 2007); and 3) *Workplace Health, Safety and Wellbeing of the Nurse* (RNAO, 2008b).

EVOLVING GOVERNANCE STRUCTURES, INFRASTRUCTURE, AND MECHANISMS

Since its selection as a BPSO, SMH has evolved its governance structures and infrastructure (e.g., positions and resources) to ensure that oversight and professional practice support are available to meet the BPSO requirements.

GOVERNANCE

Currently, BPSO activities are part of the responsibilities of the Nursing Advisory Council (NAC) and its various subcommittees. NAC is accountable to the Chief Nursing and Health Disciplines Executive as the BPSO Executive Sponsor who supports the integration of best practices into the daily operations and priorities of the organization. This high-level sponsorship enables linkages with clinical research, nursing practice, and education. SMH also established a steering committee in 2015 to lead the selection of BPG indicators to report to NQuIRE, a new requirement to maintain the BPSO Designation. The membership reflected key stakeholders in practice, education, and research, as well as management and data systems.

PROFESSIONAL PRACTICE INFRASTRUCTURE

Changes to the infrastructure of the professional practice portfolio were also made to respond to the requirements to maintain BPSO Designation. The portfolio includes a full-time position responsible for supporting the integration and sustainability of Best Practice Guidelines into daily practice. Also included is a part-time data analyst role for Professional Practice to develop processes and audit tools to support BPG evaluation at the local and corporate levels and support our NQuIRE commitments.

MECHANISMS

Over the last 8 years, several mechanisms were designed and delivered to provide learning and capacity-building opportunities for direct-care nurses, such as communities of practice, boot camps, booster sessions, and assigned mentors. Other mechanisms included fellowships and financial support for release time for nurses to participate in these offerings and lead implementation and dissemination of their respective BPG projects.

COMMUNICATING UPDATES AND SHARING ACHIEVEMENTS

Over the last 8 years, in keeping with BPSO deliverables, the Professional Practice team has also made it a top priority to profile BPSO activities, Champions, and teams who lead the work to acknowledge and recognize achievements in efforts to keep BPSO momentum across the organization. Key communication strategies associated with BPSO Designation and implementation of BPGs are listed in Table 8.2. Further, we have published aspects of our implementation processes and outcomes in scholarly and professional journals (Santiago & Smith, 2015; Thomas et al., 2016; Wannamaker, Michelsen, & Santiago, 2015).

TABLE 8.2 COMMUNICATION AND DISSEMINATION OF BPSO WORK AND IMPLEMENTATION OF BPGS

MECHANISM	DESCRIPTION
Shining the Light on St. Michael's BPSO Achievements	An annual BPSO newsletter intended to highlight some of SMH's best practice achievements with examples of how our nursing teams are implementing, evaluating, and sustaining RNAO BPGs
Nursing Week—Poster Gallery Walk Internal Media Nursing Rounds Professional Practice Scenario of the Month	BPSO activities are continuously profiled through regular nursing columns in internal media, nursing week events, nursing rounds, internal intranet, and the "Professional Practice Scenario of the Month," ensuring our BPSO Designation and activities remain at the forefront of SMH.
BPSO Symposium	A corporate BPG showcasing opportunity with oral and poster presentations
Standing Ovations	Standing ovations were first introduced at our BPSO Symposium in November 2010. The BPSO Project Management Team and SMH executives travel to the clinical areas where BPGs have been implemented. Local-level clinicians present their BPG implementation activities and receive thanks and a standing ovation for their accomplishments.
BPSO Intranet	Our BPSO intranet site was developed and continually updated and includes all the components of our BPSO work.
BPSO Poster and BPSO Pins	As part of our designation celebration, we created a poster that highlighted each BPG implementation team with a team photo and a brief description of their successes to date, along with key messages from SMH executives. Each nurse received a copy of the poster and a BPSO pin to commemorate our BPSO Designation.
BPG Nurse Champion and Mentor Pins	During the annual SMH Nursing Week BPG Sustainability Poster Gallery Walk event, BPG Nurse Champions and Mentors are awarded a pin to recognize and celebrate their role in implementing and evaluating BPGs in their respective areas.

EVALUATING IMPACT

We have evaluated implementation of BPGs since the BPSO candidacy period both corporately and at local unit/team levels using research, quality-improvement, and program evaluation methods. A few key evaluation activities are highlighted.

NQUIRE

A select number of BPGs are being monitored and evaluated through NQuIRE. The steering committee is following a systematic approach to the BPG indicator selection process. Each indicator within the RNAO BPG data dictionaries (DD) was assessed by our steering committee based on the following considerations: 1) alignment with corporate/programmatic initiatives or priorities; 2) current data-collection activities (processes and sites); 3) matching of definitions and timing; 4) planned data-collection activities; 5) current and future feasibility; 6) data owners and partners; and 7) type of measure.

The following are five BPG indicators that were selected using this process: 1) "Minutes to receive pain medication" (*Assessment and Management of Pain*); 2) "Treated with courtesy and respect" corporate-wide (*Client Centered Care*); 3) "Falls rate" (*Prevention of Falls in*

Older Adults); 4) "Exclusive breastfeeding rate"; and 5) "Formula supplementation rate" (*Breastfeeding*).

CARE UTILIZING EVIDENCE (CUE) AND CUE-QI (QUALITY IMPROVEMENT) INITIATIVES

The CUE dashboard is a corporate audit and feedback mechanism that shares BPG-related outcome and process data with direct-care nursing staff. It has become a valuable way for clinicians and unit managers to see the impact of their care on patients, stay on track, monitor for trends, and identify opportunities for ongoing improvement through regular review and follow-up (Jeffs, 2014; Jeffs et al., 2014).

In addition, a series of research studies has been carried out exploring patient safety, nurse and organizational outcomes, and experiences associated with an integrated approach to BPG implementation. The results clearly demonstrate the positive relationships between client and provider outcomes and clinical and HWE BPG implementation in our organization (Beswick, Westell, Sweetman, Mothersill, & Jeffs, 2013; Jeffs, 2014; Jeffs, Acott, Simpson, et al., 2013; Jeffs, Beswick, Acott, et al., 2014; Jeffs, Beswick, Campbell, et al., 2013; Jeffs, Beswick, Lo, et al., 2013; Jeffs, Cardoso, et al., 2013; Jeffs, Lo, Beswick, & Campbell, 2013; Jeffs, Sidani, et al., 2013; Jeffs et al., 2012).

SPREADING AND SUSTAINING BPGS AT ST. MICHAEL'S HOSPITAL

A set of strategies has been developed (see Table 8.3) for spreading and sustaining BPGs into daily workflow processes and functions.

TABLE 8.3 SPREAD AND SUSTAINABILITY STRATEGIES

STRATEGIES	DESCRIPTION
Sustainability Community of Practice	Monthly BPG Sustainability Communities of Practice meetings to exchange experiences and knowledge.
Sustainability Workshops	Expanded 6-hour workshop is targeted at Sustainability Evaluation Fellows and others in leadership positions. Prerequisite to attendance is completed evaluation plans and associated Plan-Do-Study-Act cycling.
BPG Sustainability Template	This template is circulated bi-annually to all clinical areas as a mechanism to report back to Nursing Professional Practice on BPG implementation, evaluation, and sustainability activities. This becomes part of an organization-wide report to track BPG-related activities at the local and corporate levels.

LEVERAGING EXTERNAL FUNDING AND PARTNERSHIP OPPORTUNITIES

Integral to our successful ongoing BPSO Designation have been the opportunities to leverage external funding and partnerships. This includes use of research funding to evaluate BPG impact. We have been active participants with the Nursing Best Practices Research Centre (NBPRC) and are also involved in BPG development and review teams and BPSO applicant selection panels.

LESSONS LEARNED

Our BPSO is a large site with over 2,000 registered nurses and related stakeholders. Making minor practice changes is a challenge, let alone a major change in culture that the BPSO Designation entailed. Some of the key lessons learned that were and continue to be critical to our BPSO successes include:

- Develop and use plans throughout
- Engage direct-care staff in planning, implementing, leading, disseminating, and evaluating

- Use multiple innovative strategies to initiate, sustain, and boost
- Develop and engage Champions at all levels
- Align strategically with overall organizational priorities
- Involve the senior leadership team

FUTURE PRIORITIES

Into the future, we continue to build capacity and support Champion/team development and success through:

- Offering a monthly BPG Community of Practice
- Establishing a formal BPG Nurse Champion mentorship model
- Providing BPG Nurse Champions with protected time to lead BPG initiatives

SMH will continue to align BPSO activities—including the spread, sustainability, and adoption of new RNAO BPGs—with other corporate priorities. We will also continue to contribute to RNAO's NQuIRE database, routinely assess newly published BPG data dictionaries, and seek opportunities to leverage NQuIRE reports and processes with other corporate priorities.

Through these BPG initiatives and others, SMH is able to make strides toward ensuring our patients and their families are receiving the highest-quality care possible and are safe throughout their healthcare journey with us.

CONCLUDING PERSPECTIVES FROM THE BPSO ORGANIZATIONAL LEADERS

In this chapter, nursing leaders from five BPSOs representing all sectors and ranging from early to recent cohorts have shared their BPSO story. Each has described the motivation to become a BPSO, getting started, successes and challenges, overall organizational impact, what BPSO looks like in their organizations today, as well as future perspectives. In summary:

- Toronto Public Health has reshaped its nursing and interprofessional teams to focus on evidence-based practice and nursing leadership through the development of Best Practice Guideline Champions and storytelling.
- Bluewater Health, a community hospital, has "hardwired" its organization with Best Practice Guidelines, including the *Person-and Family-Centred Care* BPG, and has set the stage for a patient-oriented cultural revolution.
- The North Bay Nurse Practitioner-Led Clinic has used the BPSO Designation to connect with community stakeholders to build a strong interprofessional team through the use of BPGs to guide practice in a consistent way.
- Bayshore Home Health has spread the Best Practice Guidelines across the nation and maximized their impact within the community and home care sector through interprofessional evidence-based practice and use of evidence-based nursing order sets.
- St. Michael's Hospital, a large acute-care setting, has implemented numerous Best Practice Guidelines to create and sustain a "tsunami" of evidence-based practice across its entire organization.

CONCLUSION

New BPSO challenges and successes are yet to be experienced in our organizations and in yours. One thing we know for sure is that nursing leaders need to be committed to maximizing the impact of Best Practice Guidelines on both patient/client outcomes and nursing practice. There is no need to approach this work on your own. Connect with the other nursing leaders in your region, your province, your country, and the world. Becoming part of the international BPSO movement can be a transformational step for your organization. Connect with the Registered Nurses' Association of Ontario to explore how you can begin your own BPSO journey. Share ideas, innovations, and resources. Know that patients, families, employees, volunteers, physicians, and donors are counting on you to lead . . . and to get it right. We must be curious. We must be compassionate. We must be courageous!

KEY MESSAGES

Although there were significant differences in our healthcare sectors, geographical locations, and organizational size and complexity, there were commonalities for nursing leaders across all five organizations. The authors of this chapter believe that it may be helpful to readers to consider these alignments. All are shared through the perspective of the firsthand experiences of those who have been or are currently immersed in this incredible work, with the intent of maximizing success.

- It is essential to *ignite the desire* to become a Best Practice Spotlight Organization (BPSO) across the organization, including your board of directors. The Senior Leadership Team must be visibly supportive and committed to this goal. It is important to use existing committees and departmental structures as platforms and levers for the work.
- It is critical to *align the decision* to proceed to becoming a BPSO with your Mission Statement, current Strategic Plan, and Quality Plan. *Don't wait for your next Strategic Plan or next Quality Plan. Start where you are. Work with what you have.* Look at your Quality Plan to see where your targets are related to the Best Practice Guidelines. Assess the environment and timing. What else is happening? *It's ideal if there is an appetite, a pull, a gap, and strategic structures in place.* Begin by choosing the specific Best Practice Guidelines (BPG) that will have the most impact, significance, and appeal to get started. *Look for early wins.* You will have noticed through our stories in this chapter that each of our organizations selected the BPGs that would give them the early traction needed for knowledge transfer, translation, and eventual impact.
- *Clarify that this is not a project.* The BPGs must align with the current goals of the board, executive, directors, managers, and educators. It is critical for this to become the *real* work and part of your regular workflows, not an add-on. Fulfilling your care philosophy *is* your mission. This work has a beginning and no end.
- *Set a realistic budget.* There are positions you may need to create, training and development on BPGs to provide, expenses to back-fill positions so staff can attend the training, events to plan, and reasons for celebration(s).

- *This work takes feet on the ground, yours, and other senior leaders*. We need to be seen, and our supportive voices need to be heard. Get out there. See for yourself. Talk with patients, clients, and families (mostly listen). Set aside the time. Ask questions. Find out what is real. Create opportunities for dialogue with direct-care interdisciplinary staff, physicians, the chair of quality committee of the board, managers, and directors. Be appreciative. Become the face of the BPSO work.
- *Open the Best Practice Champion opportunity to interprofessional staff.* They are eager to learn and to step into this work. The inclusivity also supports collaborative practice as outlined in the *Developing and Sustaining Interprofessional Health Care* BPG (RNAO, 2013b) and enhances quality outcomes. Set and communicate practice expectations for scope and role. Involve human resources, clinical educators, union leadership, managers, and directors. Being a Champion is not an easy task. Let them know they have your support.
- *Take advantage of all RNAO supports* to build capacity in evidence-based clinical excellence, implementation science, and leadership, as wonderful opportunities for direct-care staff and others.
- *Assign a Best Practice Lead* as the point-person for all BPGs and Champions. Have the right person in the role. The candidate is typically a master's-prepared nurse with a passion for the work. This person needs to exude an energy that excites people and invites them into the best-practice experience.
- *Form alliances with Community College/University health program(s)*. Include the students and faculty in orientation and celebrations. These young professionals are our future.
- *Leverage resources* such as your Corporate Communications Team (if you have one) or RNAO to help tell your stories and cover your progress and celebrations. They'll take photos, help with presentations, include stories in communications, help with branding of the work, and make sure that publications include information related to BPSO. Keep your local media and local politicians informed about the work you are doing.
- *Believe that your people want to do meaningful work*, have purpose, make a positive difference, and feel part of things. Acknowledge that they know best what needs to change. Use your nursing leadership role and influence to insist that movement forward requires patients, clients, and families to be involved. This is not up for debate. It is non-negotiable.
- *Know that your RNAO coach is a wise strategic and operational partner* with you. Attend RNAO events. Get involved. Present at RNAO educational events. Tell your stories. Publish the work your organization is doing.

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