LEVERAGING EVIDENCE, LEADERSHIP. AND COLLABORATION TO BUILD BEST PRACTICE EBP PROGRAMS AND ACHIEVE RESULTS

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Evidence to Support the Use of the ARCC Model to Advance and Sustain EBP throughout Healthcare Systems

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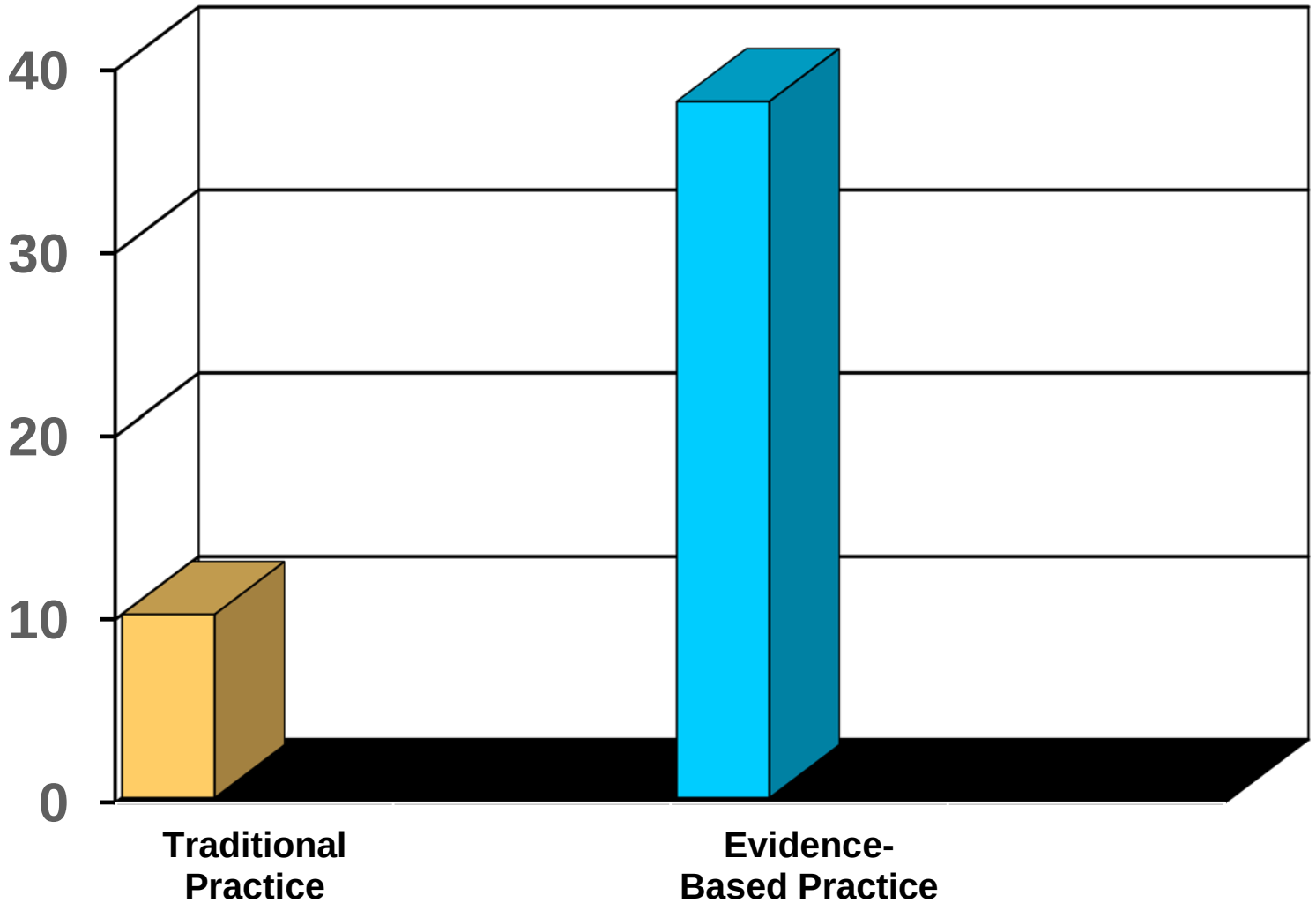
VP for Health Promotion, University Chief Wellness Officer
Dean and Professor, College of Nursing
Executive Director, Helene Fuld National Institute for EBP
The Ohio State University

The State of U.S. Healthcare and Health

- Preventable medical errors are a major cause of morbidity and mortality throughout the world (3rd cause of death in U.S.)
- The delivery of evidence-based care is highly variable with estimates of it occurring only 50 to 55% of the time
- Poor quality healthcare costs billions of dollars every year
- Healthcare spending could be reduced by 30% if patients receive evidence-based healthcare

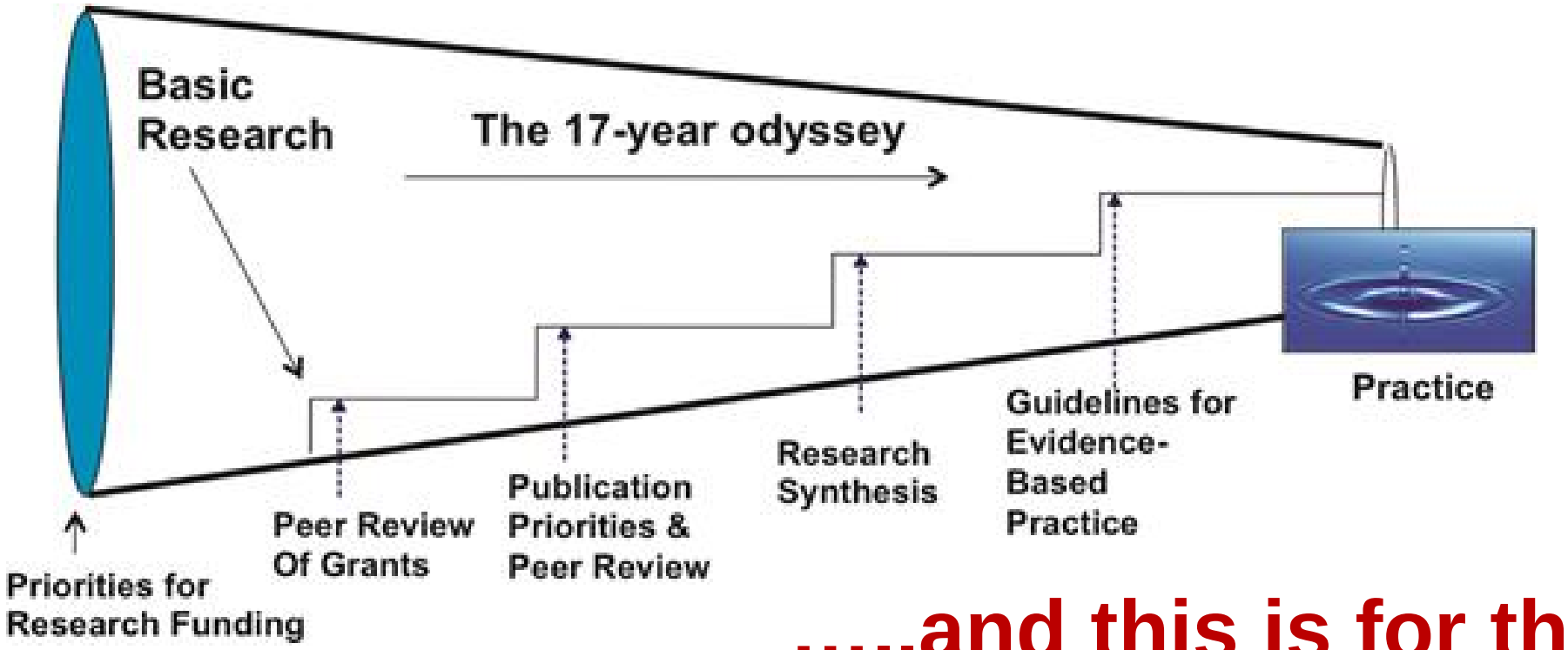
Patient Outcomes With and Without Evidence-Based Practice



EBP = The Quadruple Aim in Healthcare

- Enhance the patient experience (includes quality)
- Improve population health
- Decrease costs
- Improve the work life of healthcare providers

Research to Practice Gap



…..and this is for the 14% that make it

Balas EA, Boren SA. Managing clinical knowledge for health care improvement. In: Bemmel J, McCray AT, eds. *Yearbook of medical informatics.* Stuttgart: Schattauer; 2000: 65– 70.

Kaylin's Story:

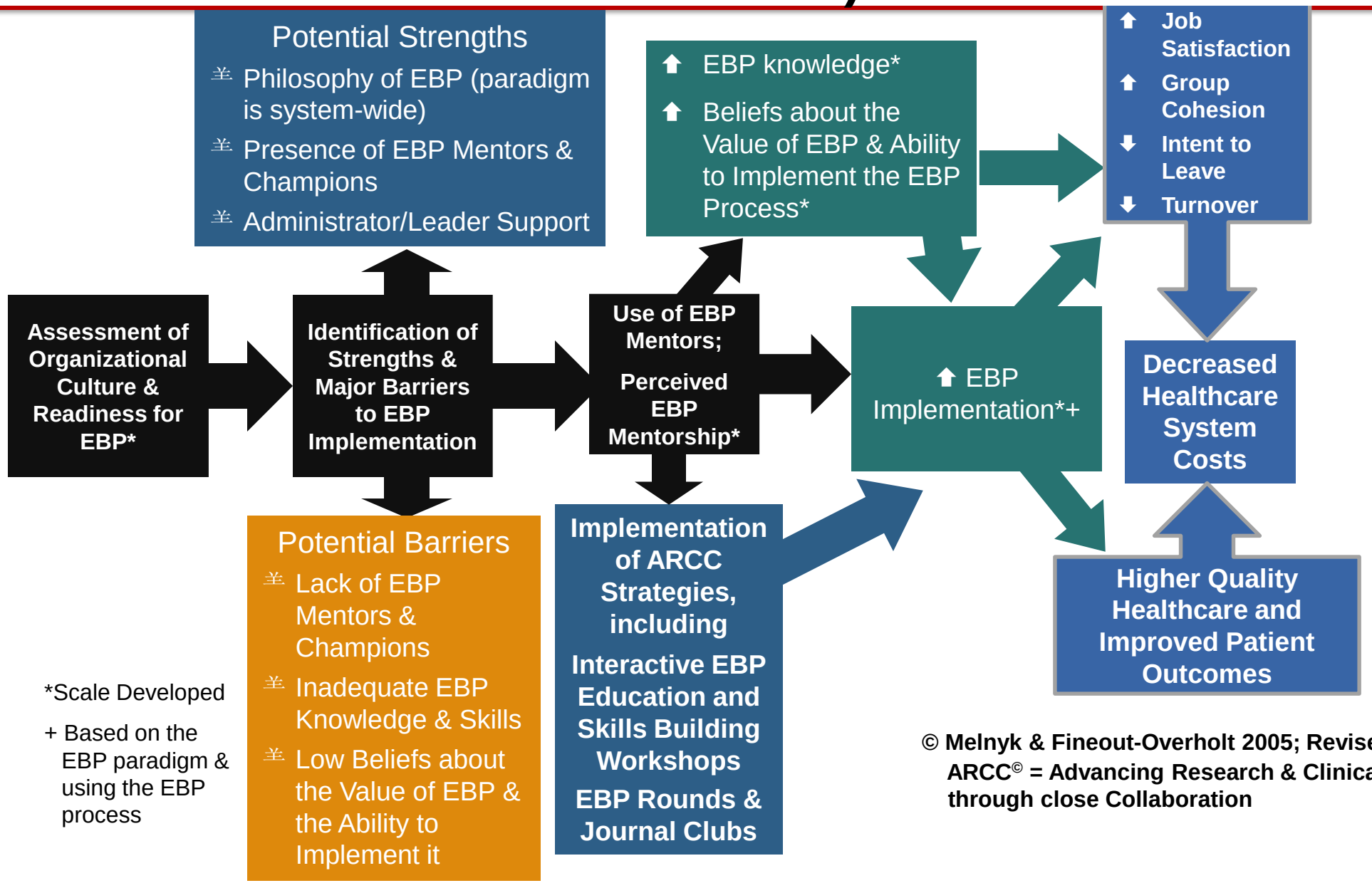
Australian Dream Trip Turned Nightmare

From Melnyk, B.M., & Fineout-Overholt, E. (2011).
Implementing EBP: Real World Success Stories

Evidence-based Practice Process Models

- The Johns Hopkins Nursing Evidence-Based Practice Model (Dearholt & Dang, 2012)
- The Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001)
- The Model for Evidence-Based Practice Change (Rosswurm & Larabee, 1999),
- The ACE Star Model of Knowledge Transformation (Stevens, 2012)

The ARCC© (Advancing Research and Clinical practice through close Collaboration) Model



*Scale Developed

+ Based on the EBP paradigm & using the EBP process

ARCC© = Advancing Research & Clinical practice through close Collaboration

Multiple Studies Support the ARCC© Model

Study #1: Descriptive correlational study with 160 nurses

Study #2: A psychometric study of the EBP beliefs and EBP implementation scales with 360 nurses

Study #3: A randomized controlled pilot study with 47 nurses in the VNS

Study #4: A quasi-experimental study with 159 nurses in a clinical research medical center environment

Study #5: A pre-experimental study with 52 clinicians at Washington Hospital Healthcare System

Outcomes of Implementing the ARCC© Model at Washington Hospital Healthcare System

- Early ambulation in the ICU resulted in a reduction in ventilator days from 11.6 to 8.9 days and no VAP
- Pressure ulcer rates were reduced from 6.07% to .62% on a medical-surgical unit
- Education of CHF patients led to a 14.7% reduction in hospital readmissions
- 75% of parents perceived the overall quality of care as excellent after implementation of family centered care compared to 22.2% pre-implementation

Melnyk et al., 2017, *Worldviews on Evidence-based Nursing*

WORLDviews on EVIDENCE-BASED NURSING™

The First U.S. Study on Nurses' Evidence-Based Practice Competencies Indicates Major Deficits That Threaten Healthcare Quality, Safety, and Patient Outcomes

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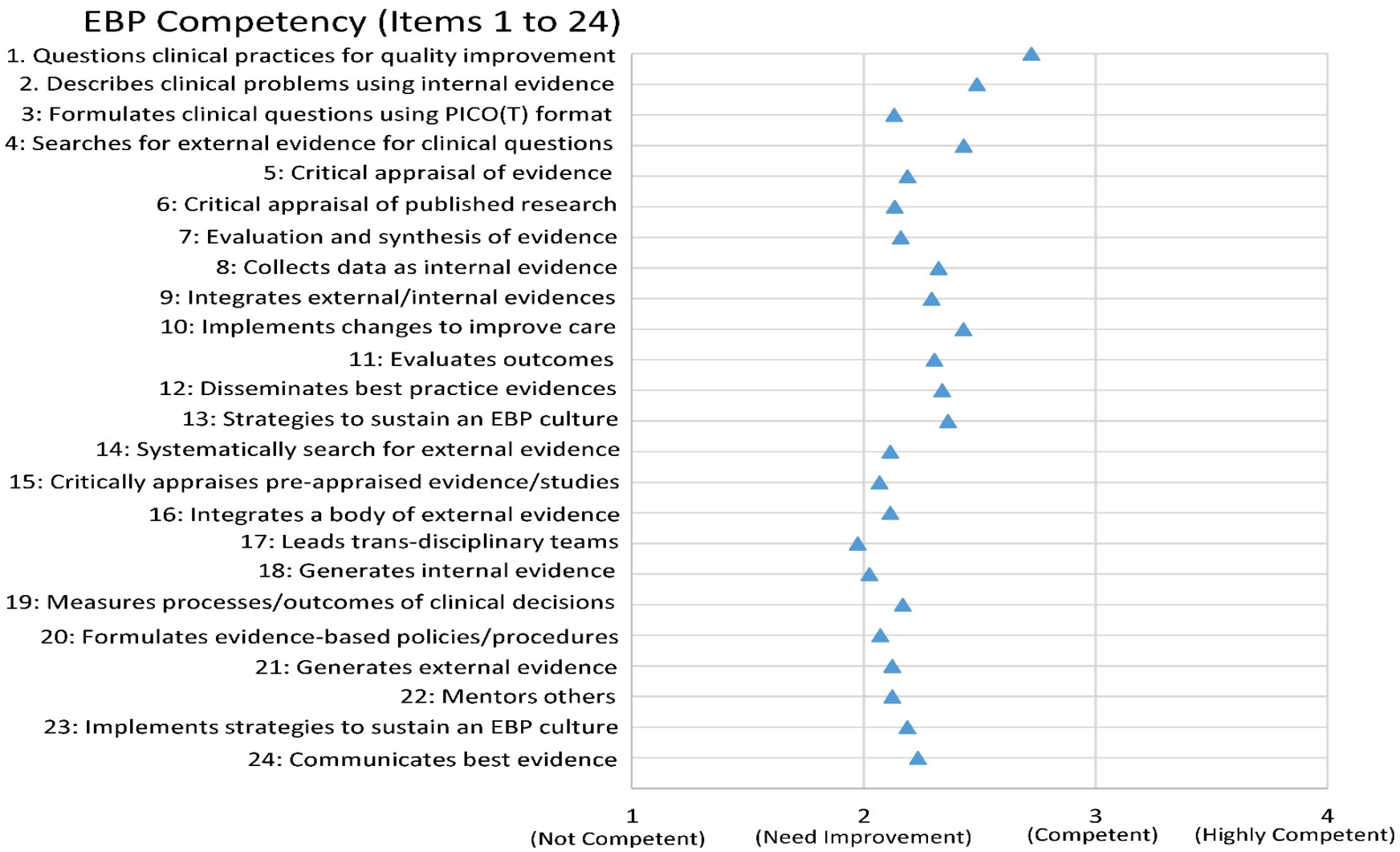
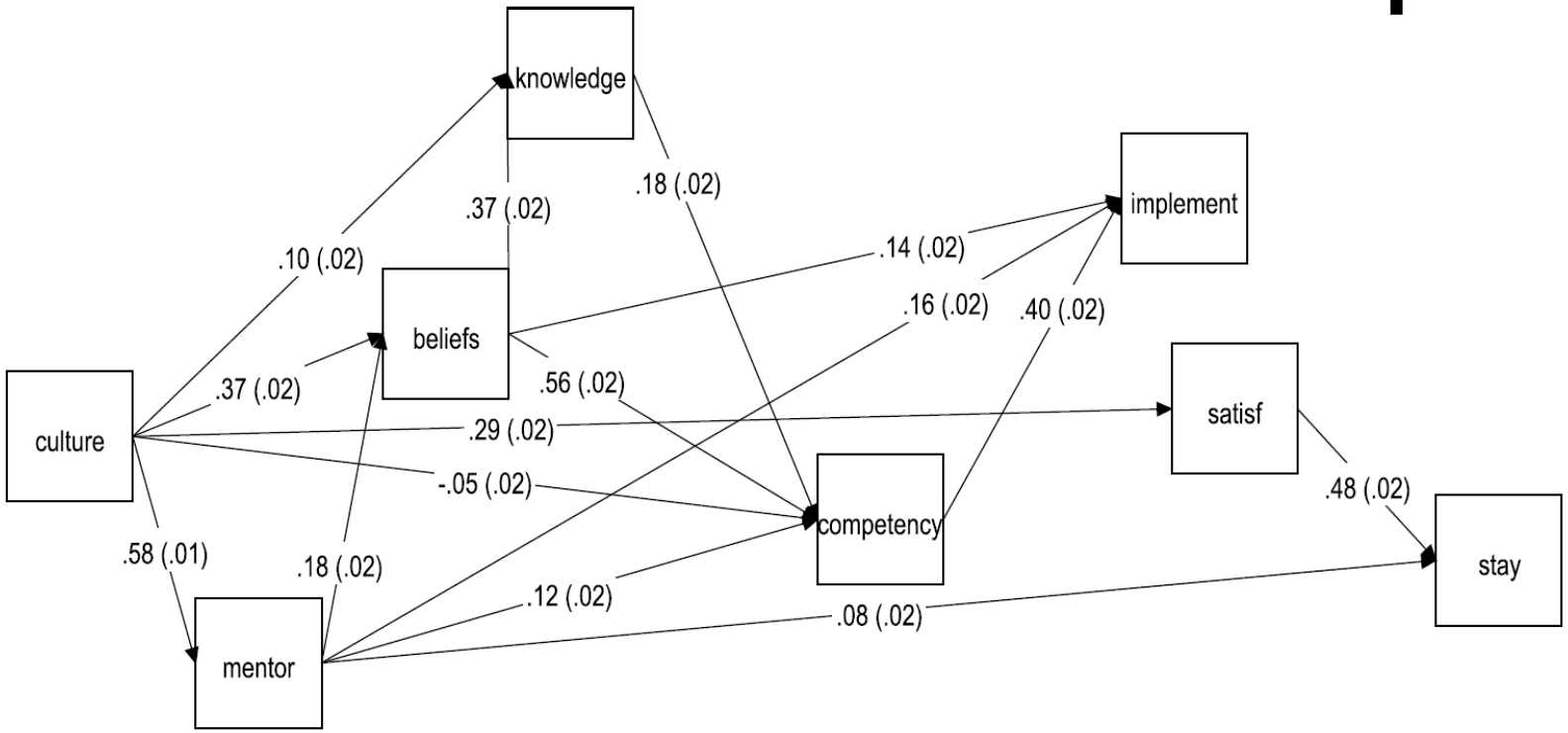
Lynn Gallagher-Ford PhD RN DPFNAP NE-BC
Cindy Zellefrow DNP MSEd RN LSN PHNA-BC
Sharon Tucker PhD RN FAAN
Bindu Koshy-Thomas MSEd MS
Lorraine T. Sinnott PhD
Alai Tan PhD

Melnyk et al 2018

Reported Level of EBP Competency by the Nurses



The Latest Test of ARCC© : A Structural Equation Model



1. Figure shows the standardized coefficient (SE) of each path.
2. All paths are statistically significant.
3. The model has a close fit.
   Chi-square =84.8, df = 12, p<0.001 (due to large sample size)
   RMSEA = 0.051 (90% CI: 0.041-0.061)
   CFI =0.987
   TLI = 0.969
4. No significant modification indices

Components of the ARCC© EBP Mentor Role

- Ongoing assessment of an organization's capacity to sustain an EBP culture;
- Building EBP knowledge and skills to assist clinicians in achieving the EBP competencies by conducting interactive group skills building workshops and one-on-one mentoring
- Stimulating, facilitating, and educating staff toward a culture of EBP, with a focus on overcoming barriers to best practice;
- Role modeling EBP

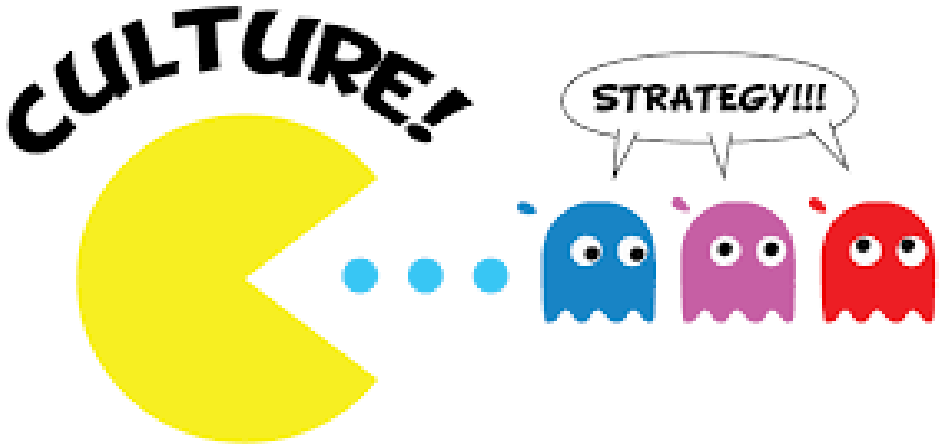
Components of the ARCC© EBP Mentor Role

- Conducting ARCC© EBP enhancing strategies, such as EBP rounds, journal clubs, newsletters, and fellowship programs;
- Working with staff to generate internal evidence through EBPI/evidence-based quality improvement projects
- Using evidence to foster best practice; and
- Collaborating with interdisciplinary professionals to advance and sustain EBP throughout the system

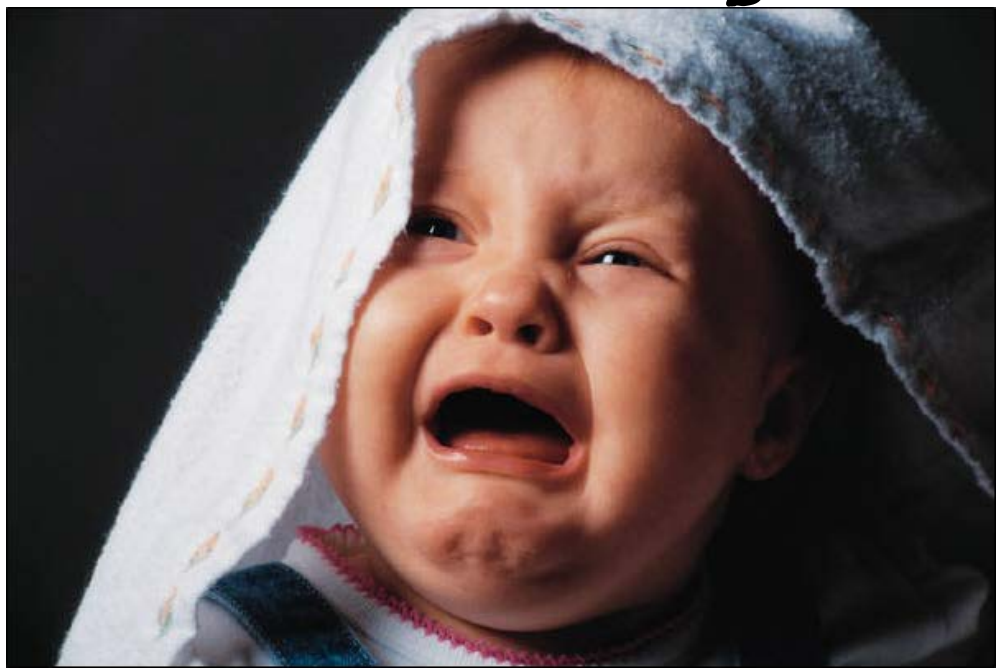
Creating an Organizational Culture and Environment to Sustain EBP

A Key Role for ARCC© EBP Mentors

Remember,
Culture Eats Strategy!



The only person that likes a change is a baby with a wet diaper!
ARCC© EBP Mentors Must Have Skills in Behavior Change



Critical Components of an EBP Culture

A Philosophy, Mission and Commitment to EBP:

- there must be commitment to advance EBP **across the organization as evidenced in orientation, clinical ladders, evaluations**

A Spirit of Inquiry:

- health professionals are encouraged to continuously ask questions, review and analyze practices to improve patient outcomes

EBP Mentors:

- who have in depth knowledge and skills in EBP, mentoring others, and overcoming barriers to individual and organizational culture change

Critical Components of an EBP Culture

Administrative Role Modeling and Support:	• leaders who value and model EBP as well as provide the needed resources to sustain it
Infrastructure:	• tools and resources that enhance EBP across the organization; computers for searching, up to date data bases, library resources
Recognition:	• individuals and units are rewarded regularly for EBP

Ask yourself:

What will you do if you know you can not fail in the next 2 years?

Who will you mentor and how will you facilitate a culture of EBP in the next 2 years?

Utilizing Evidence, Experience, and Intention to Build a Better EBP Program and Achieve Results

Dr. Penelope F. Gorsuch

DNP, RN, ACNP-BC, CCNS, CCRN-K, NEA-BC

Associate Director, Patient Care Services

Nurse Executive

Dayton VA Medical Center

Dayton Ohio

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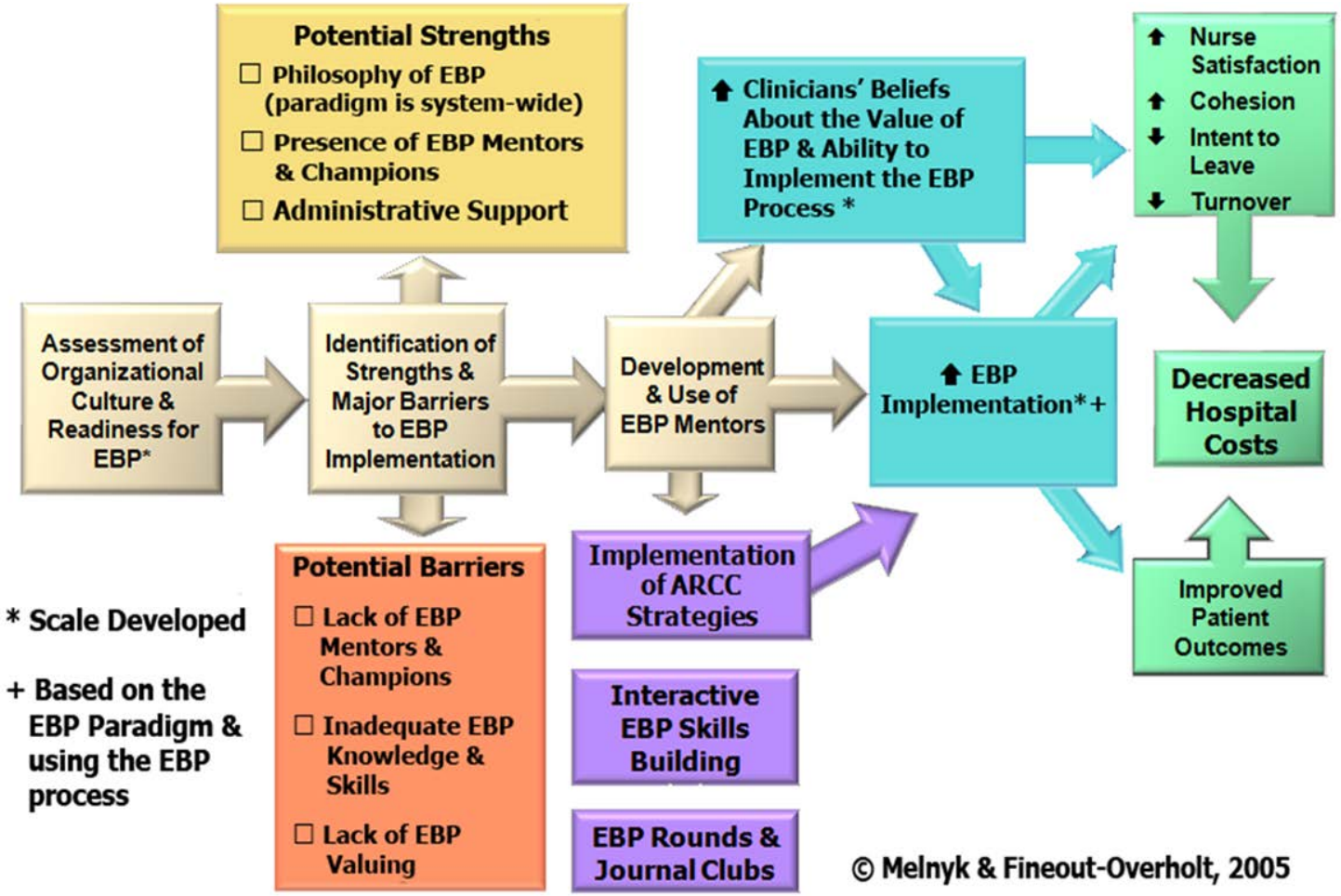
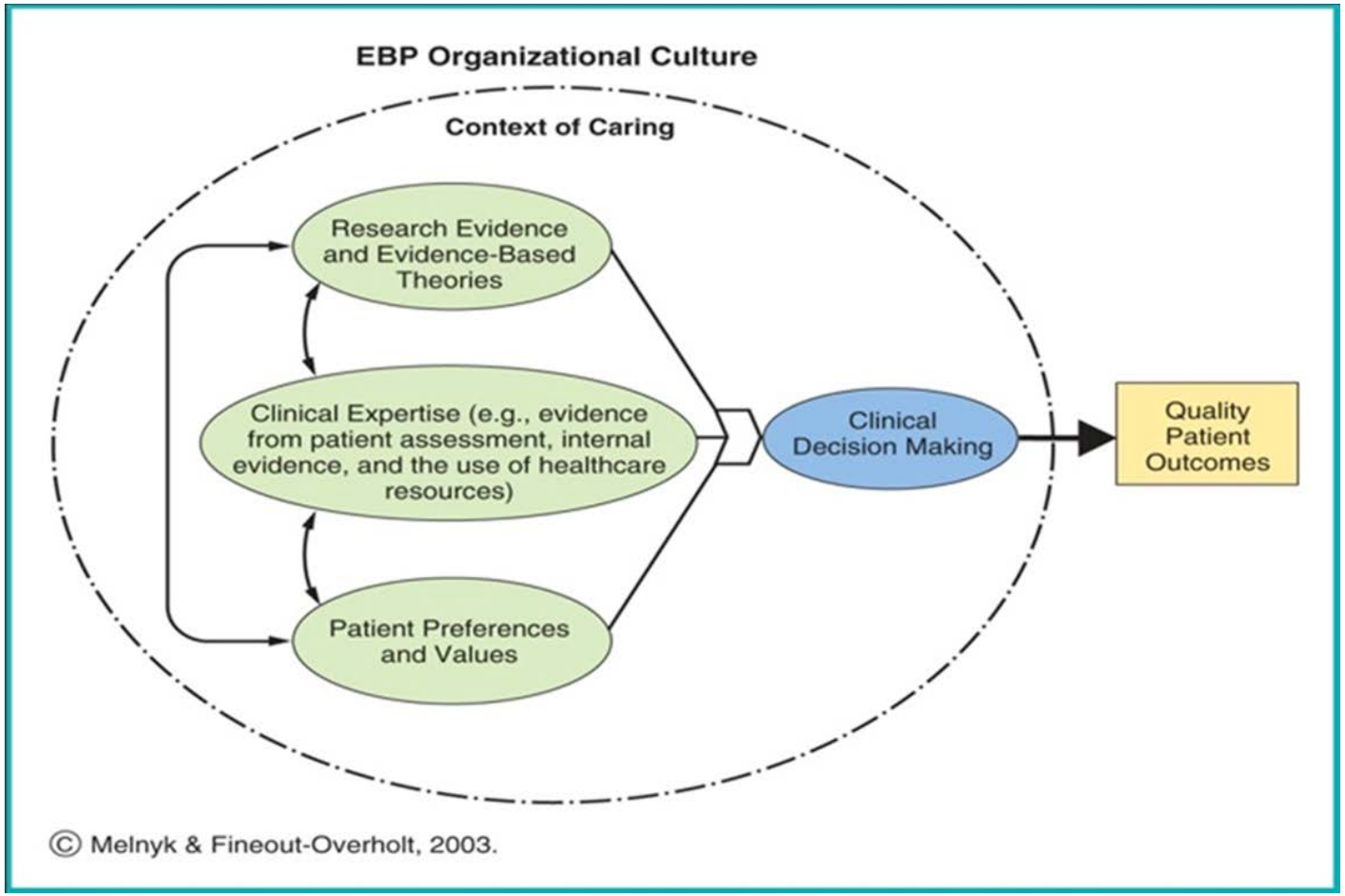
Advancing Research and Clinical Practice



EBP Culture and Environment



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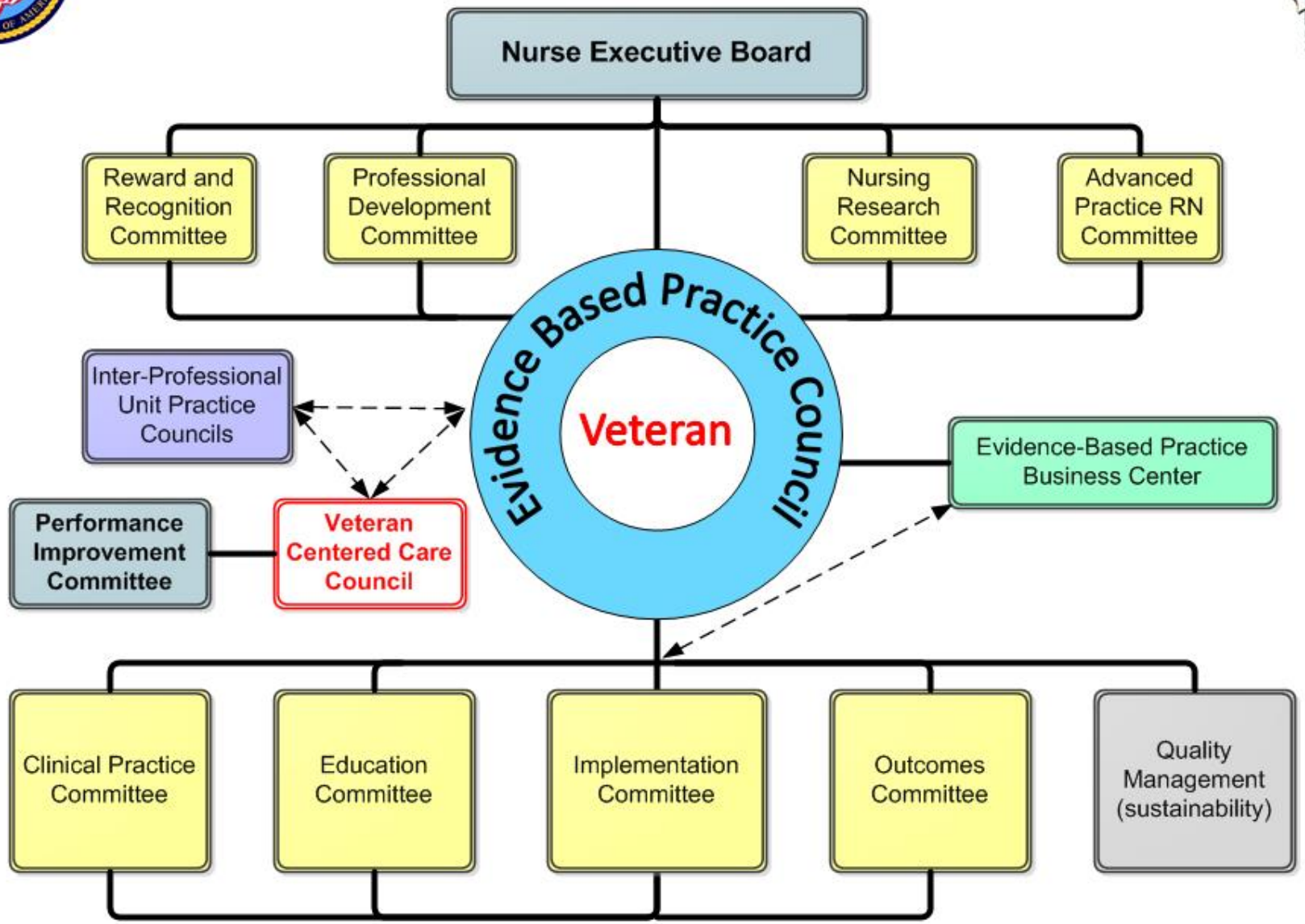
The Seven Steps* to EBP

- Step 0: Cultivate a spirit of inquiry along with an EBP culture and environment
- Step 1: Ask the PICO(T) question
- Step 2: Search for the best evidence
- Step 3: Critically appraise the evidence
- Step 4: Integrate the evidence with clinical expertise and patient preferences to make the best clinical decision
- Step 5: Evaluate the outcome(s) of the EBP practice change
- Step 6: Disseminate the outcome(s)

(*Melnyk & Fineout-Overholt, 2011)

Evidence-Based Practice Council Organizational Chart

Relationship Based Care philosophy is the theoretical underpinning for all council and committee work.



Key: Solid line = reporting relationship; Dotted line = a collaborative relationship

This diagram is confidential for the use by the Dayton VA only.

Updated 01/05/18 Gorsuch, P.; Sampsel, D.; Slonaker, P.; Worley, J.; James,E.

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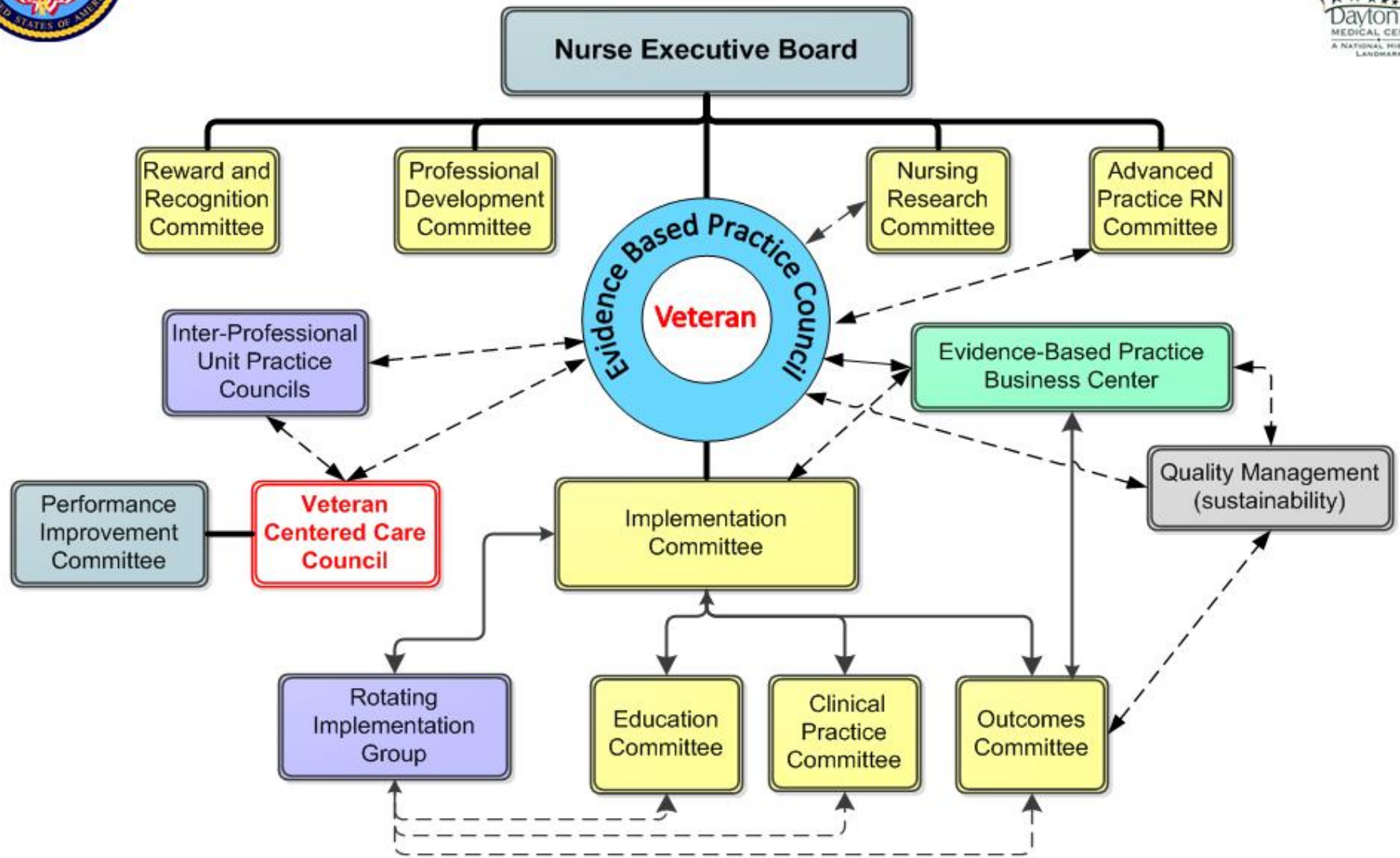
Evidence-Based Practice Implementation Structure

Relationship Based Care philosophy is the theoretical underpinning for all council and committee work.



Key: Solid line = reporting relationship; Dotted line = a collaborative relationship

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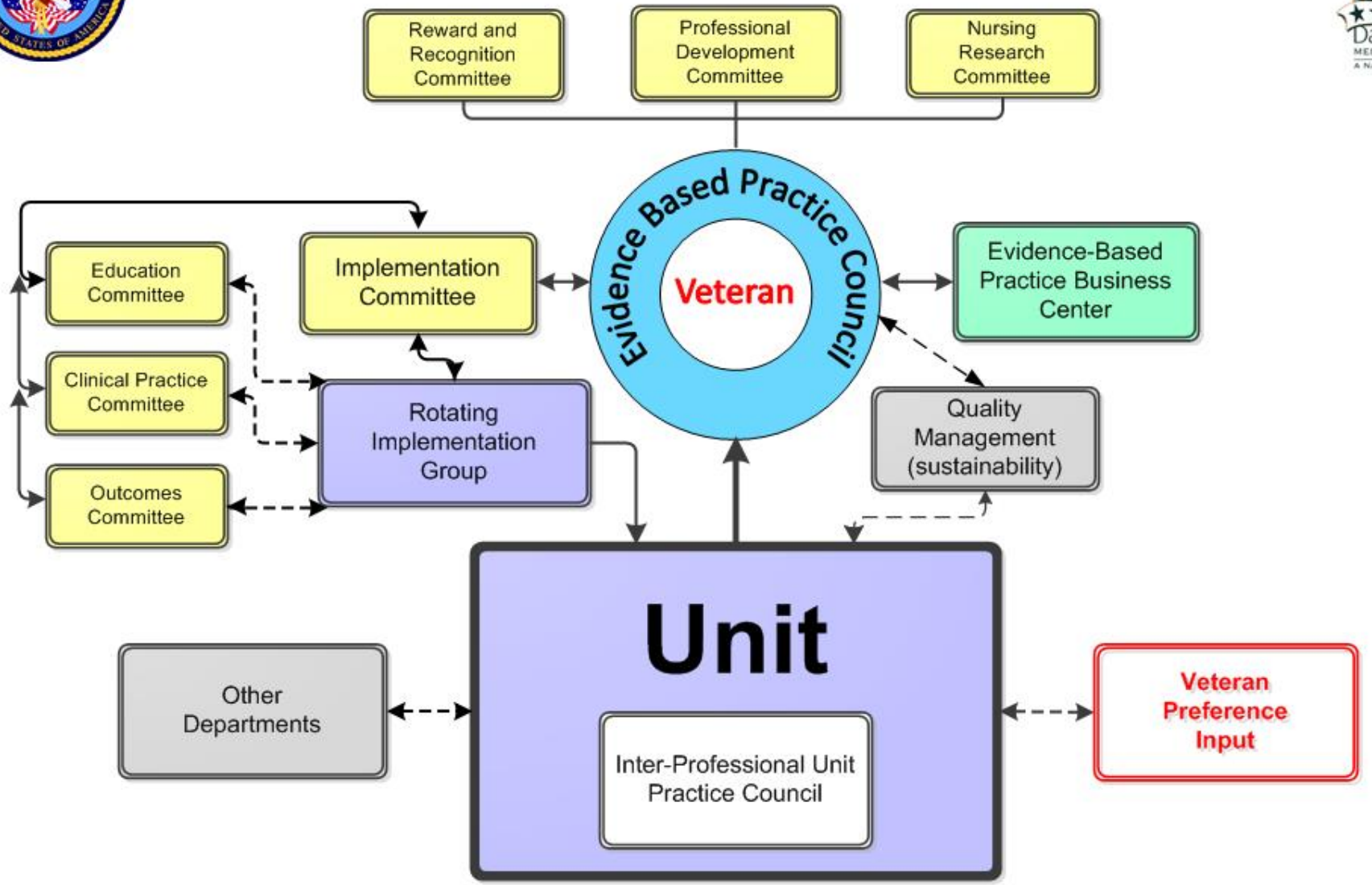
Updated 01/05/18 Gorsuch, P.; Sampsel, D.; Slonaker, P.; Worley, J.; James,E.

Evidence-Based Practice Unit Operational Chart



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Dayton VAMC Evidence-Based Practice (EBP) Spirit of Inquiry Question Form

Directions:

1. Complete the form below with a Spirit of Inquiry clinical practice question you have.
2. Share the completed form with your Nurse Manager/Supervisor for their review.
3. After you discuss the idea with your Nurse Manager/Supervisor, you will submit the original form to the Evidence Based Practice Council Chair (Debi Sampsel). Please call her at ext. 2511.

Name: _____

Department/Unit: _____

Write your Spirit of Inquiry Question here: _____

_____

_____

_____

_____

Employee Signature: _____ Date: _____

Nurse Manager/Supervisor Input:

1. Review question submission and discuss with employee.
2. Make one copy for your files, and one copy for employee.

Describe any considerations the EBP Council should be aware for determining whether or not the question moves forward such as VA Directive/Policy, scope of practice, etc.:_____

_____

_____

_____

_____

Nurse Manager/Supervisor Signature: _____ Date: _____

To be completed by EBP Council Chair	*Date:*	*Initials:*
Spirit of Inquiry form received		
Forwarded to EBP Council voting members for review		
Email invitation sent to employee to present Spirit of Inquiry at next EBP Council meeting		
Spirit of Inquiry information entered in EBP Business Center tracking database (Open vs Archived)		
Comments:		

*Reference 7 Steps: Melnyk, B. & Fineout-Overholt 2011, Evidence-Based Practice in Nursing and Healthcare, Walters-Klovwer

DVAMC EBP Business Center. This form is confidential for the use by the Dayton VA only. 01/03/18 Gorsuch, P., Sampsel, D., Worley, J., Eardley, C.

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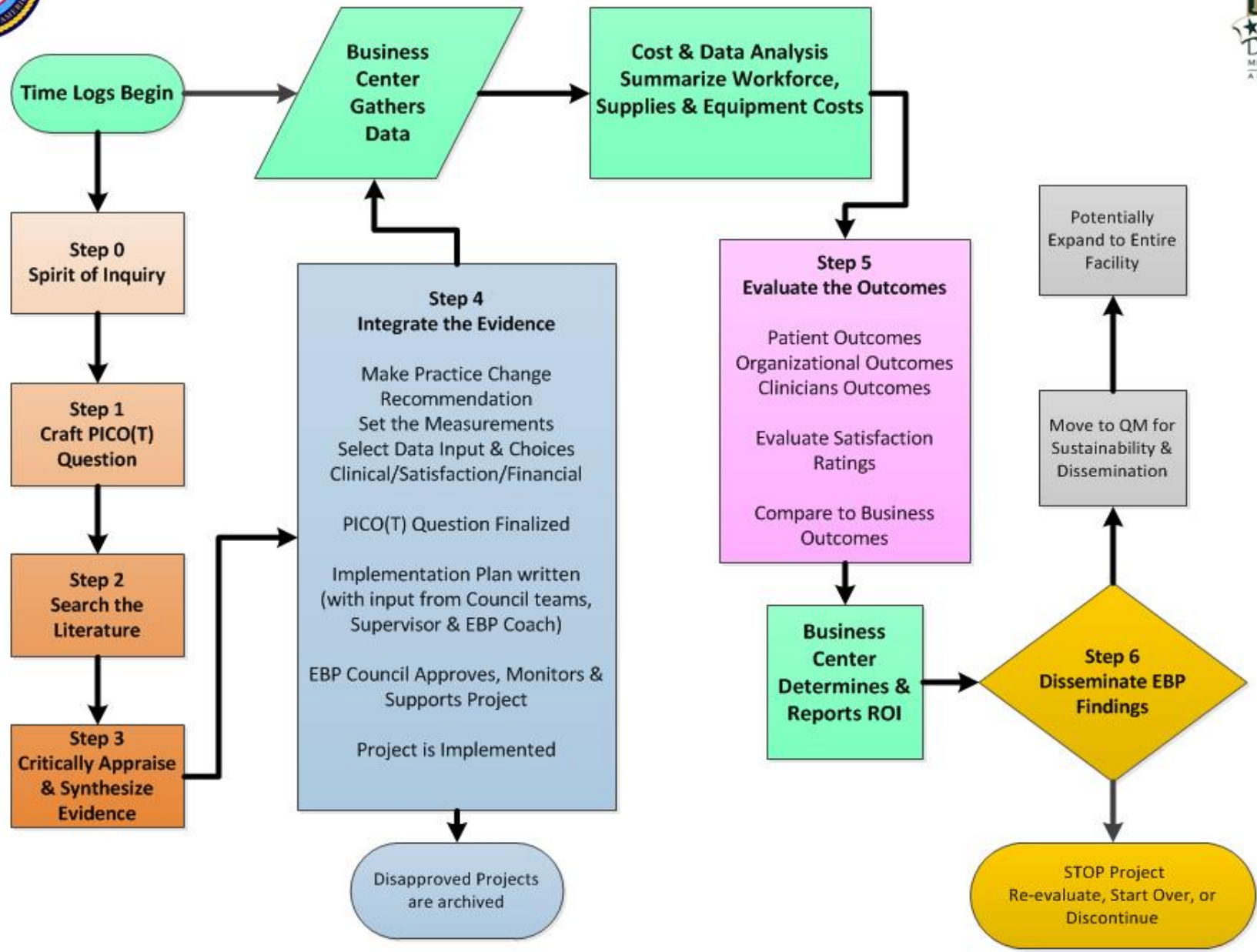
Dayton VA Medical Center EBP Process Business Center Model
Integrated with Melnyk's 7 Step* Process



*Reference 7 Steps: Melnyk, B. & Fineout-Overholt 2011, Evidence-Based Practice in Nursing and Healthcare, Walters-Klovwer

DVAMC EBP Business Center Design confidential for use by Dayton VA only, Updated 01/05/18 Gorsuch, P., Sampsel, D., Worley,J., Slonaker, P., James, E.

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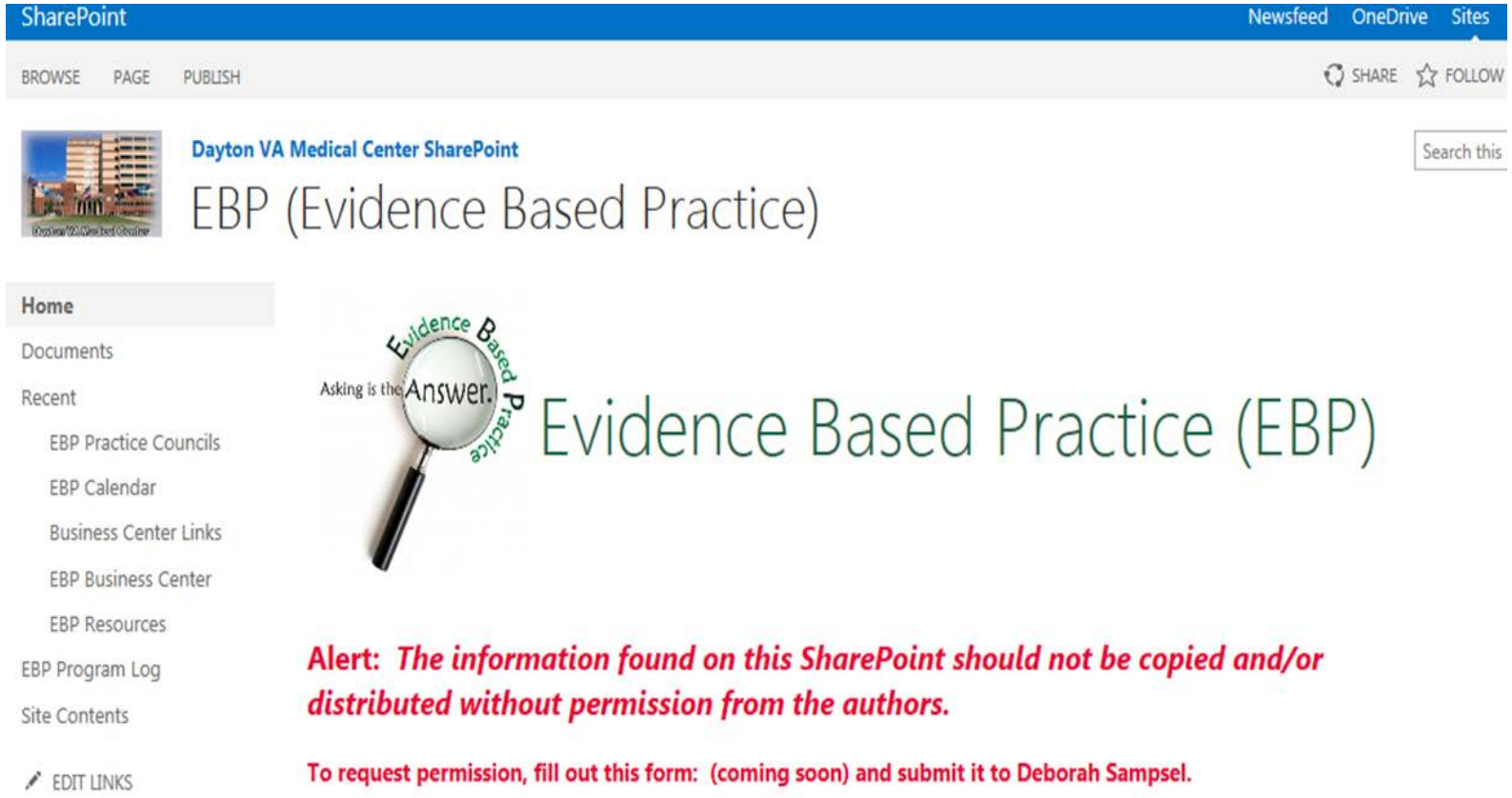
Evidence-Based Practice SharePoint Site



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Outcomes

- Engaged Executive & mid-level leadership
- Redesigned nursing shared governance structure
- Held ADPCS Strategic Planning Summit
  - Held the inaugural Nursing Service Town Hall Meetings with Nurse Executive and all Chief Nurses presenting our strategy
- Conducted 3 In-services for staff
  - The difference between QI, EBP, & Research
  - The 7-Steps of EBP
  - EBP Leadership

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Outcomes

- Expanded the Nurse Executive Board to include all Nursing Leaders across the organization
  - Set up weekly meetings with 4 Chief Nurses
  - Led Nurse Manager Journal Club
  - Empowered Nurse Managers to lead their units
  - Supported Clinical Nurse Leaders (CNLs) in their work as EBP Mentors
- Consulted with The Ohio State University College of Nursing The FULD, on a QI Project on Building EBP Advocates for 6 months educated 10 Direct Care Nurses on the 7-steps of EBP

Outcomes

- Conducted 2 EBP Immersions through OSU The FULD for 98 Interprofessional leaders at the Dayton VA (Creating EBP Mentors)
  - Expanded the EBP Council to interprofessional and open membership
  - Created a spirt of inquiry
  - Developed the structure, process and outcome measurements processes
  - Created EBP Business Center
    - Tracks staff cost (FTE)
    - Tracks ROI

Outcomes

- Dayton VAMC Best Place to Work (Quality) score is VA
- Ranked 53 out of 129 VA facilities for the RN turnover rate
  - Improved 44.8%

- Nursing Sensitive indicators:
  - Falls decreased by 11%
  - 39 less pressure ulcers throughout our facility (1 pressure ulcer is average at $60K additional hospital costs)
  - Missed medications down by 45%; (average medications given per month 148,000; average number of missed meds per month 0.01418)
  - Zero CLABIS
  - Zero CAUTI in Acute Care
  - Implemented CAUTI protocol to Long Term Care
    - Zero CAUTI in LTC last 6 months

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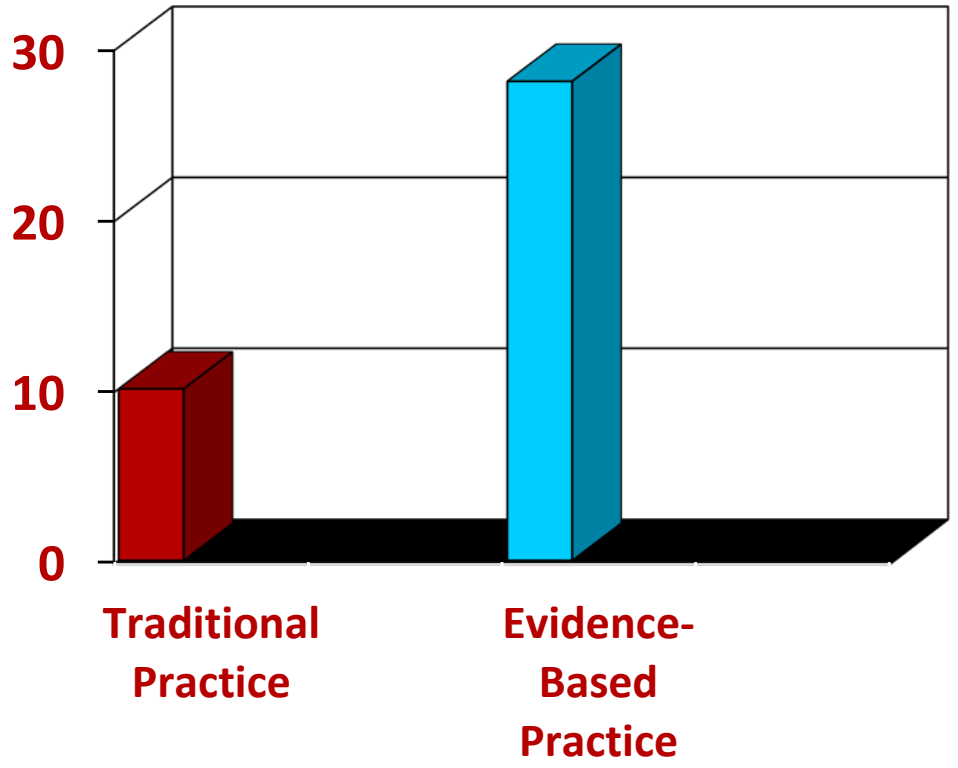
UTILIZING EXPERTISE, EXPERIENCE, AND LESSONS LEARNED TO BUILD EFFECTIVE EBP PROGRAMS THAT SUSTAIN

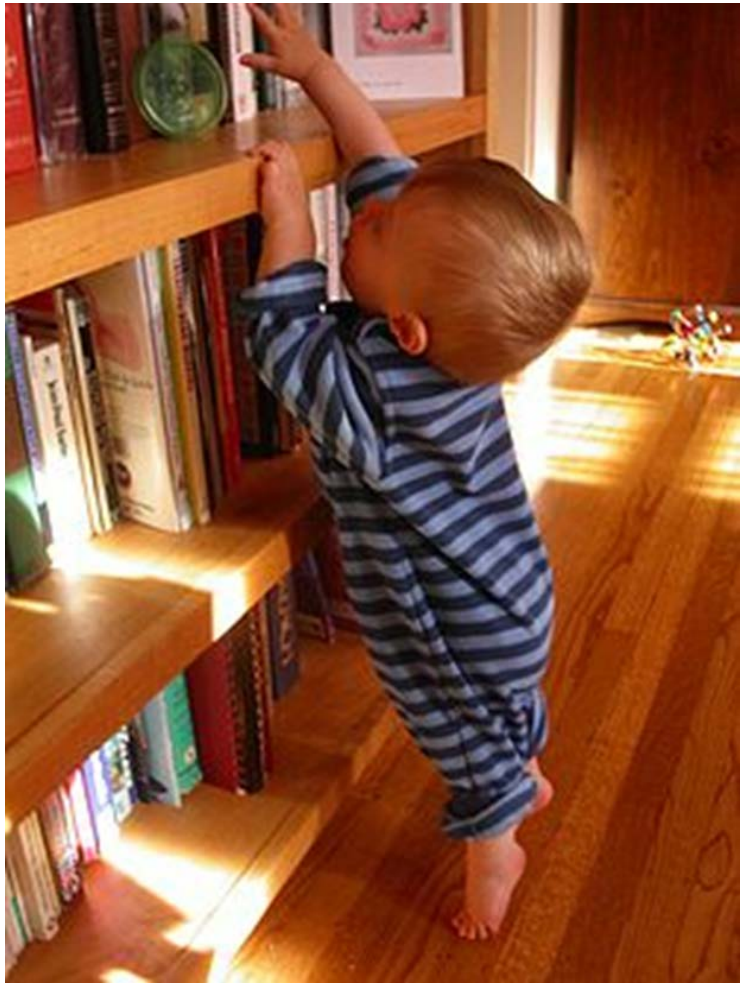
Lynn Gallagher-Ford, PhD, RN, NE-BC, DPFNAP, FAAN
Senior Director, Helene Fuld Health Trust National Institute for EBP in Nursing & Healthcare Director, Clinical Core, Helene Fuld Health Trust National Institute for EBP in Nursing & Healthcare The Ohio State University College of Nursing

Why Bother?

Patient Outcomes IMPROVE With Evidence-Based Practice



The answers to most of our questions are known!
We just don't go get the answers!



So….What's the evidence?

WORLDviews on EVIDENCE-BASED NURSING™

US Nurses Readiness for Evidence-based Practice (2005)

67% sought information only from colleagues

39% felt they “rarely or never” needed information

58% reported “not using research at all to support practice”

82% never used a hospital library or a librarians’ assistance

76% had never done a CINAHL search

77% never received instruction in use of electronic databases

(Pravikoff et al., 2005)

Our 2011 EBP Study of EBP in U.S. Nurses

The State of Evidence-Based Practice in US Nurses: Critical Implications for Nurse Leaders and Educators

Melnyk, Bernadette Mazurek PhD, RN, APRN-CNP, FAANP, FNAP, FAAN;
Fineout-Overholt, Ellen PhD, RN, FNAP, FAAN;
Gallagher-Ford, Lynn PhD, RN;
Kaplan, Louise PhD, RN, ARNP, FNP-BC, FAANP

JONA: September 2012; Volume 42 (9)

Percent of Respondents Who Agreed or Strongly Agreed with the Following Statements

	%
EBP is consistently implemented in my healthcare system	53.6
My colleagues consistently implement EBP with their patients	34.5
Findings from research studies are consistently implemented in my institution to improve patient outcomes	46.4
EBP mentors are available in my healthcare system to help me with EBP	32.5
It is important for me to receive more education and skills building in EBP	76.2

The One Thing That Prevents You From Implementing EBP

1. Time
2. Organizational culture, including policies and procedures, politics, and a philosophy of "that is the way we have always done it here."
3. Lack of EBP knowledge/education
4. Lack of access to evidence/information
5. Manager/leader resistance
6. Workload/staffing, including patient ratios
7. Nursing (staff) resistance
8. Physician resistance
9. Budget/payors
10. Lack of resources

- More highly educated nurses reported being more clear about the steps in EBP and having more confidence implementing evidence-based care
- The more years in practice, the less nurses were interested in and felt it was important to gain more knowledge and skills in EBP

Study of EBP in Chief Nursing Officers

- Key Sections:
  - CNO demographics
  - Hospital metrics (core measures)
  - Patients' perspectives of care (HCAHPS)
  - Nurse-sensitive metrics (NDNQI)
  - Organizational data (e.g., % of BSNs, % of nurses certified, whether a clinical ladder system exists)
  - Highest priorities for the CNOs
  - EBP scales
  - EBP-related metrics
    - Value of EBP
    - Budget for EBP
    - Organizational structures to support EBP, councils

In association with:
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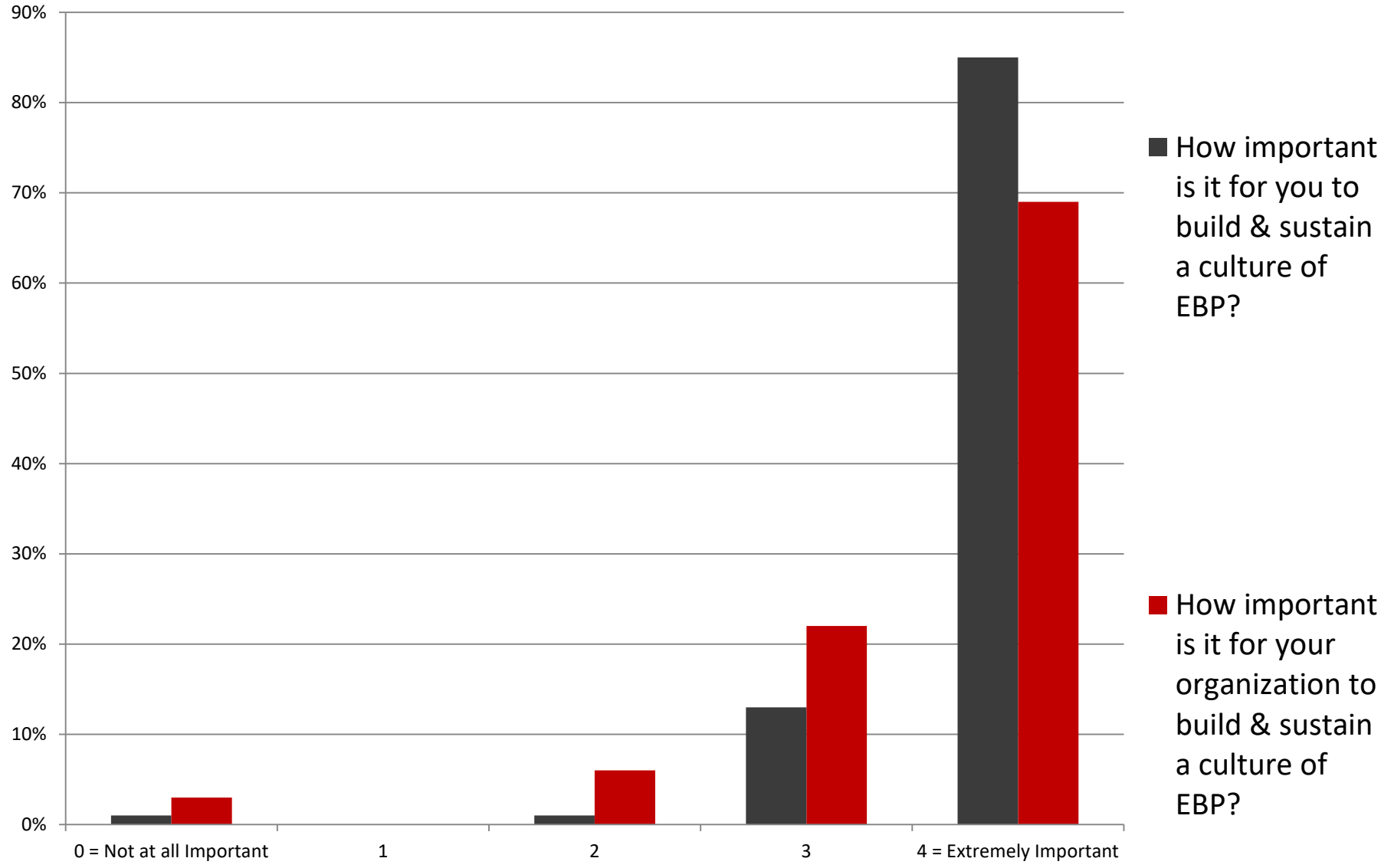
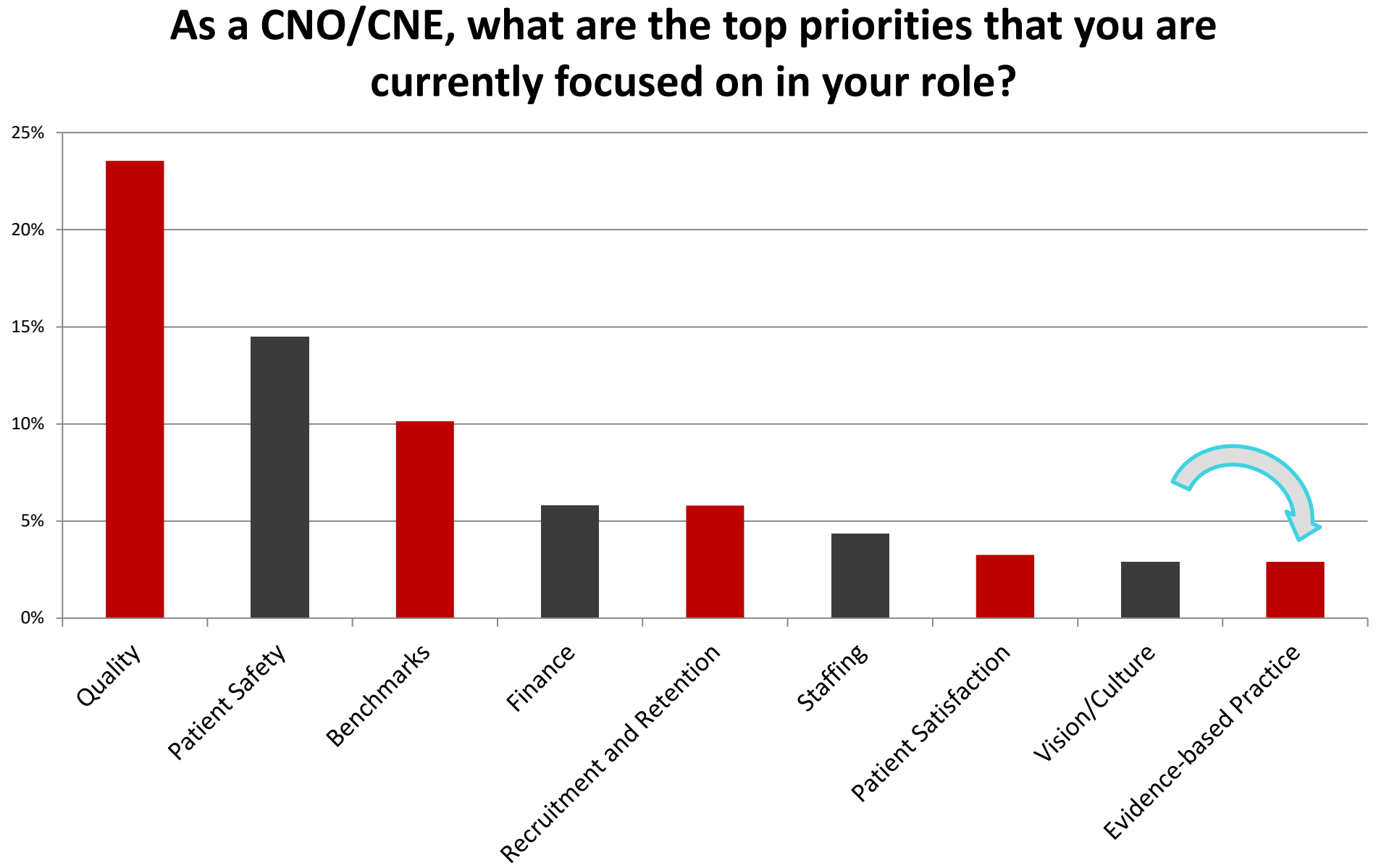
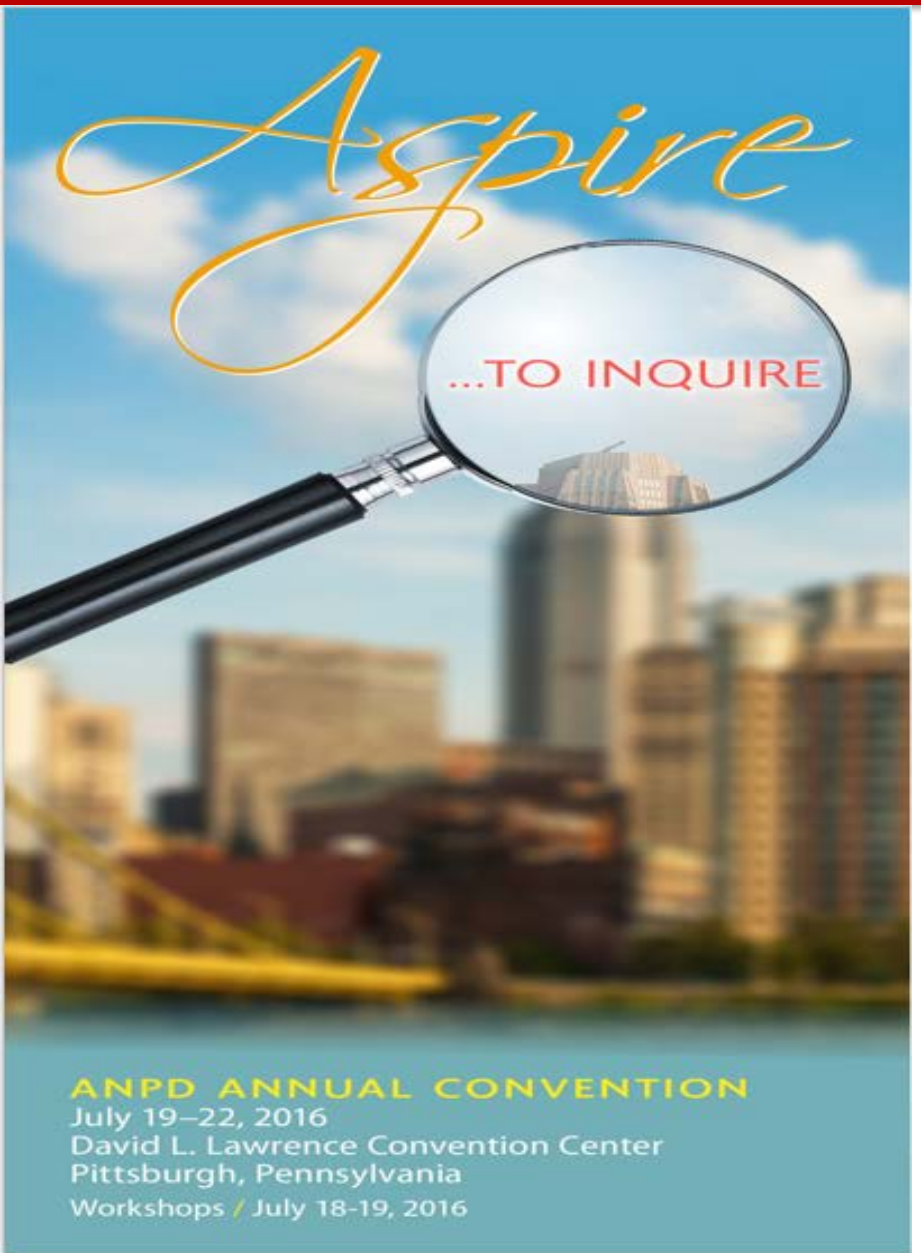
How Important is EBP



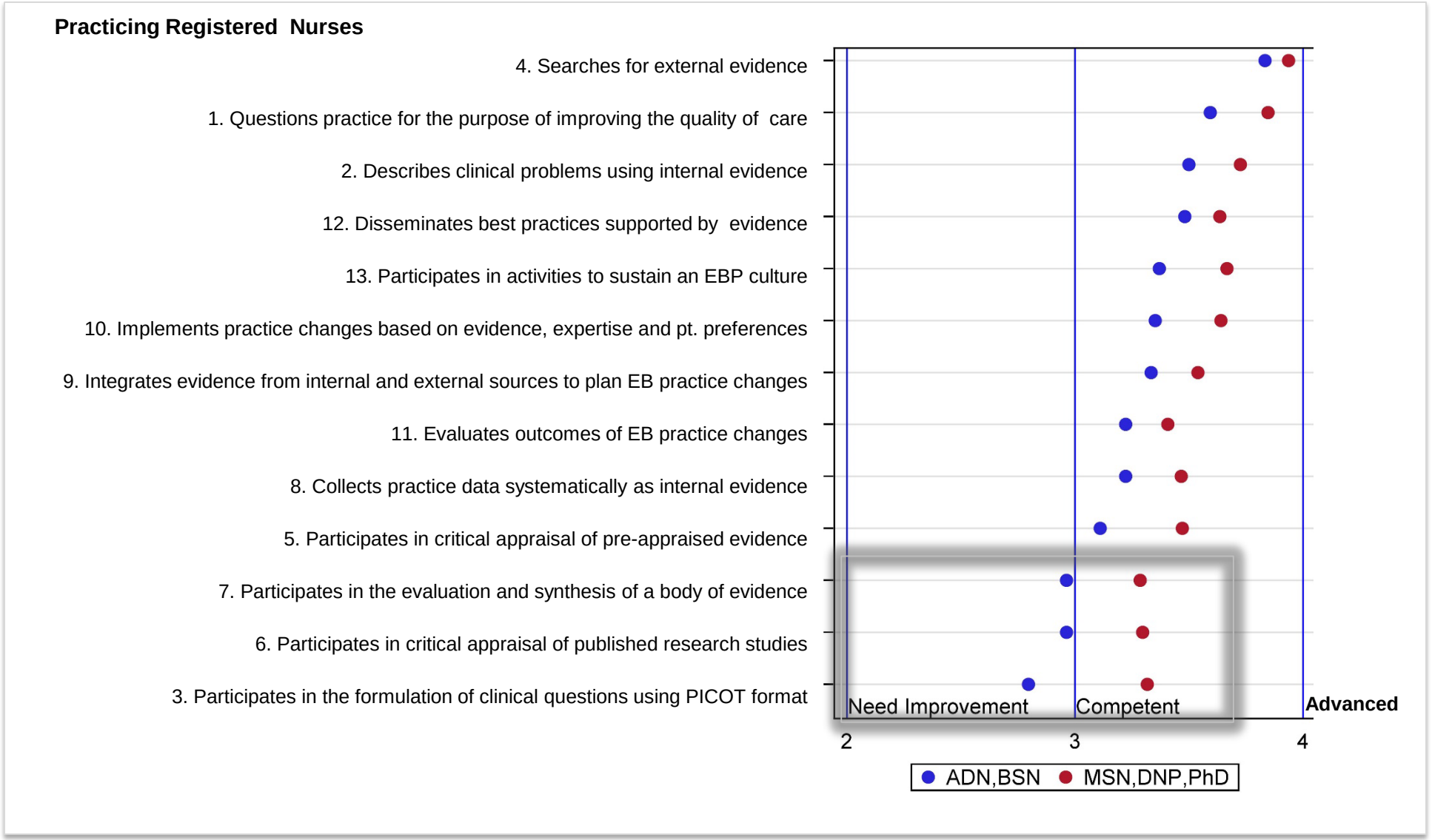
How High a Priority is EBP?



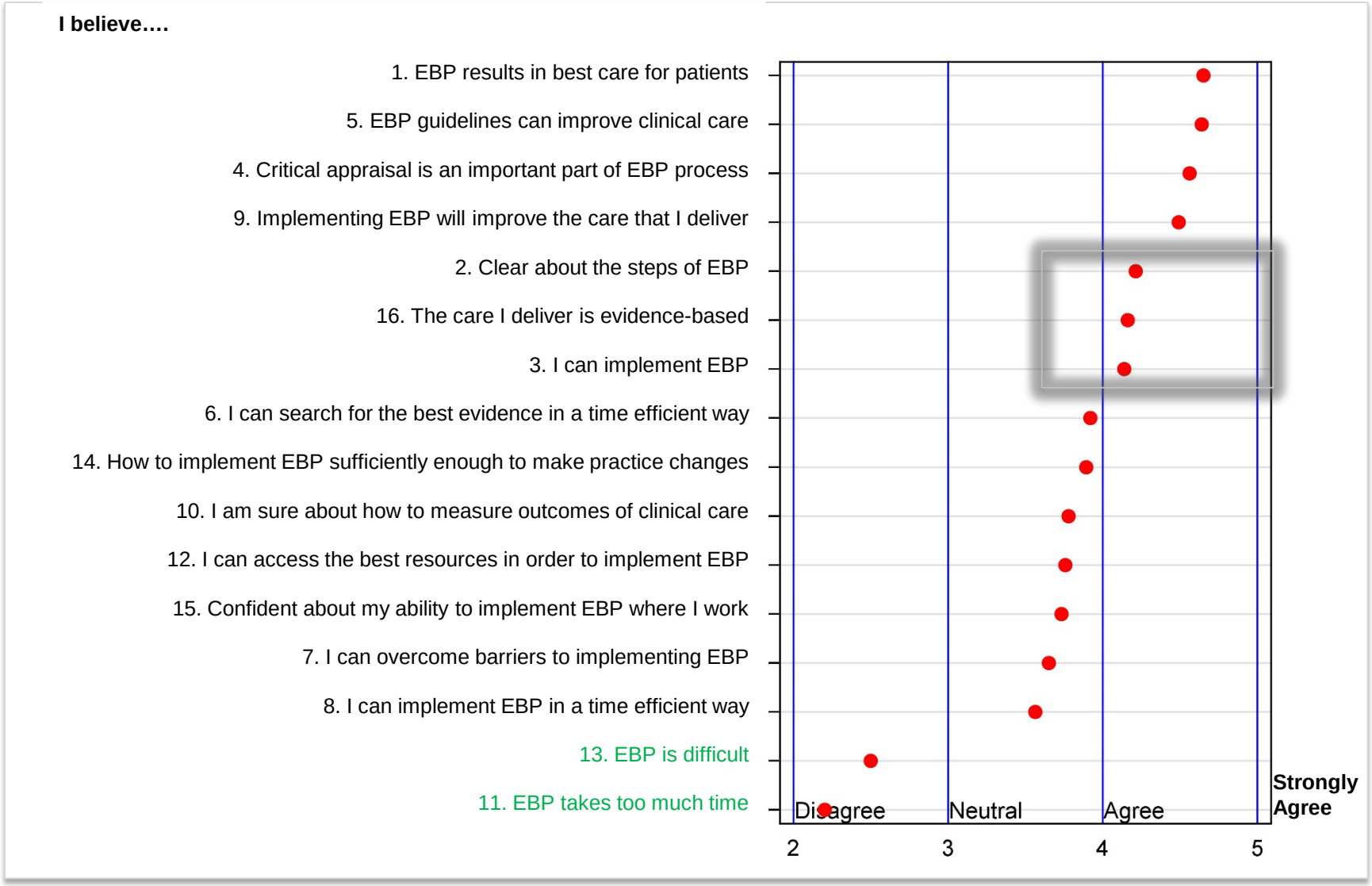


Study of EBP in Nurses in Professional Development (ANPD)

EBP Competencies



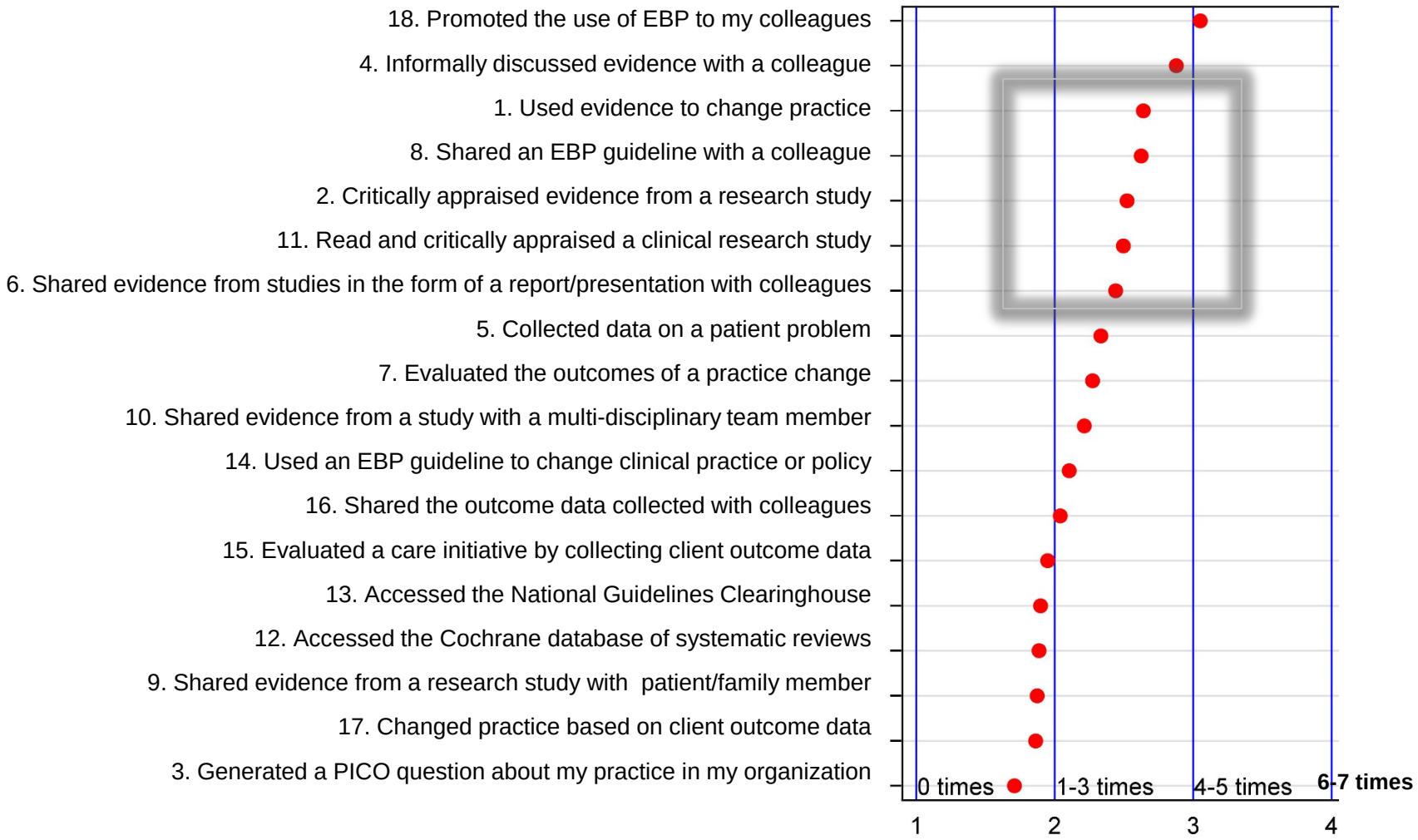
EBP Beliefs


I believe….
1. EBP results in best care for patients
5. EBP guidelines can improve clinical care
4. Critical appraisal is an important part of EBP process
9. Implementing EBP will improve the care that I deliver
2. Clear about the steps of EBP
16. The care I deliver is evidence-based
3. I can implement EBP
6. I can search for the best evidence in a time efficient way
14. How to implement EBP sufficiently enough to make practice changes
10. I am sure about how to measure outcomes of clinical care
12. I can access the best resources in order to implement EBP
15. Confident about my ability to implement EBP where I work
7. I can overcome barriers to implementing EBP
8. I can implement EBP in a time efficient way
13. EBP is difficult
11. EBP takes too much time
Disagree
Neutral
Agree
Strongly Agree
2
3
4
5

EBP Implementation

The same things they rate themselves least competent in…they are doing quite frequently!

In the past 8 weeks I have:



Editorial

Transforming Quality Improvement Into Evidence-Based Quality Improvement: A Key Solution to Improve Healthcare Outcomes

Health care in the Unites States and across the globe is undergoing extraordinary transformation. In the United States, the shift in paradigm from volume to value and fee for service to bundled payments along with managing the health of populations instead of individuals is challenging healthcare systems to redesign care to become more efficient and effective. Organizations are now continually striving to find ways to deliver safe, cost-effective care that produces the highest quality of patient outcomes. At the same time, healthcare systems are committed to improving patient, family and staff satisfaction, all within the context of a very complex and often chaotic environment. As a result of this changing paradigm, healthcare organizations are functioning in a climate of constant change, which causes stress at all levels.

In the effort to deliver high quality, safe and cost-effective care, quality improvement (QI) and evidence-based practice (EBP) have become common strategies to drive enhancements in clinical practice and improvements in patient outcomes. However, there is often confusion and a lack of clarity between QI and EBP (Hockenberry 2014; Mick 2015; Shirey et al. 2011).

Quality improvement is a systematic process used by healthcare systems to analyze existing data and improve its processes or outcomes for a specific patient population (Kring 2008; Shirey et al. 2011). There are various QI models used by healthcare organizations, including the widely used Plan, Do, Study, Act (PDSA) model. In the PDSA QI model, a change is first planned based on the identification of a problem area for improvement (Plan; e.g., a hospital has a high rate of falls in older adults). Second, the plan is formed and carried out (Do; e.g., healthcare leaders provide their views and develop a plan on what should be done to decrease the fall rate, followed by implementation of the plan). Third, the results are analyzed (Study; e.g., did falls improve with the change in practice?). Fourth, actions are decided upon to continue to improve and sustain the outcome (Act; e.g., a permanent change in practice). In QI models, a comprehensive review and critical appraisal of research evidence is typically not emphasized or conducted. As a result, QI practices are often implemented based on what individuals think may improve the problem instead of using the best evidence to drive the change. This common brainstorming tactic is popular because it can be conducted quickly and ideas can be generated and implemented rapidly. The problem is that, in this approach, the "solutions" are usually ideas and the process is simply trial and error. If the goal of the QI process is to find the best solution with the most likely chance of successful resolution of the problem, then the current reactive fast fix approach needs to be replaced with a thoughtful evidence-based approach.

Unlike research that has a purpose to generate new knowledge, EBP is a problem-solving approach to the delivery and improvement of health care that integrates the best evidence from rigorous research and combines it with a clinician's expertise, including internal evidence from patient assessment and data gathered in the healthcare system, and patient preferences and values (Melnyk & Fineout-Overholt 2014). There are seven steps in EBP (see Table 1; Melnyk & Fineout-Overholt 2014). In Step 0 of EBP, the problem is identified through a spirit of inquiry. However, unlike the typical QI model, the problem is placed within the context of a PICO (i.e., Patient population; Intervention or area of interest; Comparison intervention or group; Outcome) clinical question in order to drive a comprehensive search for best evidence and its critical appraisal. Once the best evidence is found and critically appraised, it is integrated with a clinician's expertise and patient preferences or values to determine whether a practice change should be made. Once an EBP change is made, data is gathered to evaluate the outcomes. The final step in EBP is disseminating the evidence so that others can benefit from the change.

Because EBP uses both external evidence generated from rigorous research and internal evidence generated by the healthcare system and integrates this evidence with clinician expertise and patients' preferences or values to make the best informed decisions about what type of practice change should be made, it is an exemplar for evidence-based QI. Incorporating key steps of EBP into QI models (see Table 1) will strengthen their effectiveness. Consistently using the combination of EBP, evidence-based QI, and research when there is not sufficient high quality evidence to guide practice will lead to the best health care and patient outcomes. **WVN**

Worldviews on Evidence-Based Nursing, 2015; 12:5, 251–252.

What is the goal?

Quality improvement is a systematic process used by healthcare systems to analyze existing data and improve its processes or outcomes for a specific patient population (Kring 2008; Shirey et al. 2011).
Example: PDSA QI model:

- a change is (PLAN)NED based on brainstorming solutions to a problem/area for improvement
- the plan carried out (DONE)
- results are analyzed (STUDY)
- (ACT)ions are decided upon to continue to improve and sustain the outcome.

Table 1. Strategy for Transforming Quality Improvement Into Evidence-Based Quality Improvement

Steps of EBP[a]	Incorporating EBP steps to create evidence-based quality improvement
(1) Develop a spirit of inquiry	Plan (the plan should incorporate the first four steps of EBP, including searching for and critically appraising the evidence)
(2) Ask the question in PICO format	
(3) Search for the evidence	
(4) Critically appraise the evidence	
(5) Integrate the evidence with clinician expertise and patient preferences to make a clinical decision	Do
(6) Evaluate the outcome	Study
(7) Disseminate the outcome	Act (sustain the improvement)

[a]From Melnyk and Fineout-Overholt (2014).

Evidence-based Quality Improvement is the ANSWER!

EBP → good idea (best practice)

QI → good process

Bad idea + bad process = bad outcome

Good idea + bad process= bad outcome

Bad idea + good process = bad outcome

ONLY…

Good idea + good process = good outcome

WORLDviews on EVIDENCE-BASED NURSING™

The Establishment of Evidence-Based Practice Competencies for Practicing Registered Nurses and Advanced Practice Nurses in Real-World Clinical Settings: Proficiencies to Improve Healthcare Quality, Reliability, Patient Outcomes, and Costs

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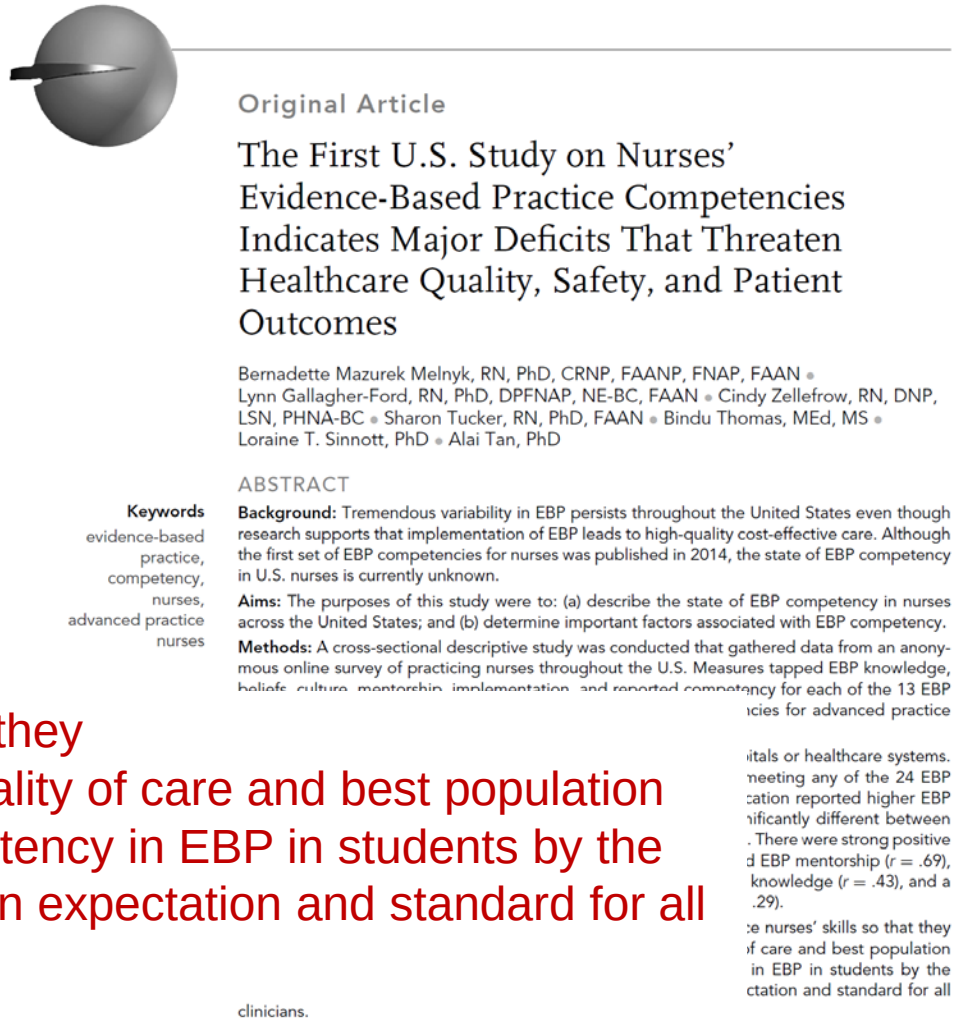
Lisa English Long, RN, MSN, CNS
Ellen Fineout-Overholt, RN, PhD, FAAN

EBP Competence Amongst US Nurses; 2017



Original Article

The First U.S. Study on Nurses' Evidence-Based Practice Competencies Indicates Major Deficits That Threaten Healthcare Quality, Safety, and Patient Outcomes

Bernadette Mazurek Melnyk, RN, PhD, CRNP, FAANP, FNAP, FAAN • Lynn Gallagher-Ford, RN, PhD, DPFNAP, NE-BC, FAAN • Cindy Zellefrow, RN, DNP, LSN, PHNA-BC • Sharon Tucker, RN, PhD, FAAN • Bindu Thomas, MEd, MS • Loraine T. Sinnott, PhD • Alai Tan, PhD

ABSTRACT

Keywords evidence-based practice, competency, nurses, advanced practice nurses

Background: Tremendous variability in EBP persists throughout the United States even though research supports that implementation of EBP leads to high-quality cost-effective care. Although the first set of EBP competencies for nurses was published in 2014, the state of EBP competency in U.S. nurses is currently unknown.

Aims: The purposes of this study were to: (a) describe the state of EBP competency in nurses across the United States; and (b) determine important factors associated with EBP competency.

Methods: A cross-sectional descriptive study was conducted that gathered data from an anonymous online survey of practicing nurses throughout the U.S. Measures tapped EBP knowledge, beliefs, culture, mentorship, implementation, and reported competency for each of the 13 EBP

icies for advanced practice

itals or healthcare systems.
neeting any of the 24 EBP
cation reported higher EBP
nificantly different between
. There were strong positive
d EBP mentorship ($r = .69$),
knowledge ($r = .43$), and a
.29).
e nurses' skills so that they
f care and best population
in EBP in students by the
ctation and standard for all

clinicians.

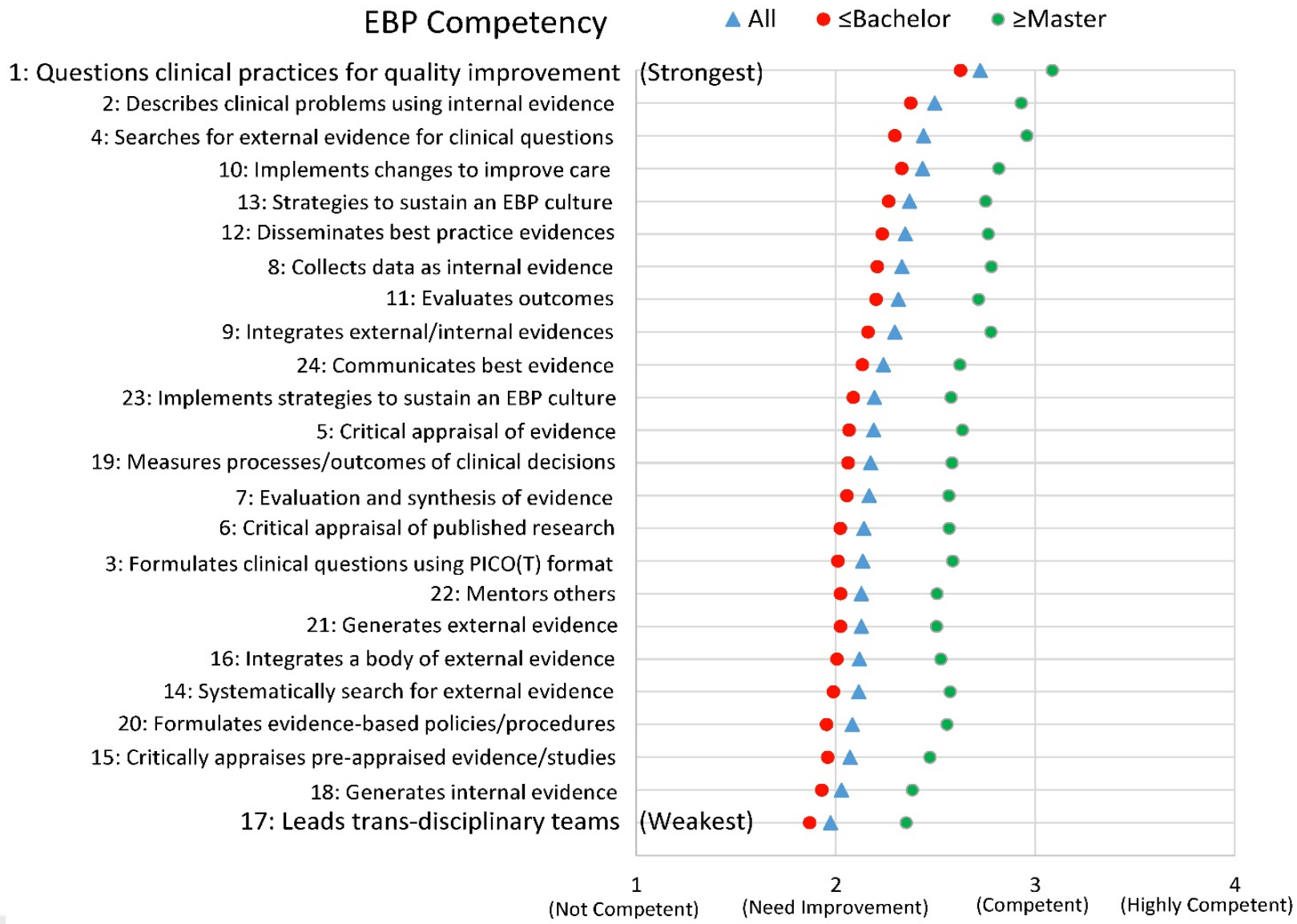
There is a tremendous need to enhance nurses' skills so that they achieve competency in EBP in order to ensure the highest quality of care and best population health outcomes. **Academic programs** should ensure competency in EBP in students by the time of graduation and **healthcare systems** should set it as an expectation and standard for all clinicians.

Correlations among EBP Competency and EBP Culture, Knowledge, Beliefs and EBP Mentoring

	Mean (SD)	Pearson Correlation Coefficient			
		Competency	Culture	Knowledge	Beliefs
Culture	80.2 (21.9)	0.29	–	–	–
Knowledge	19.5 (7.0)	0.43	0.28	–	–
Beliefs	56.7 (8.5)	0.66	0.47	0.42	–
Mentoring	21.4 (10.9)	0.69	0.69	0.24	0.47

$P < 0.001$ for all the Pearson correlation coefficients

State of Self-reported EBP Competencies by Nurses Across the United States (N = 2075)



Evidence-based Practice Readiness; A Concept Analysis

(Schaefer, J. & Welton J., 2018)

- **NURSING**
- **Plural**; a collective **group** of qualified nurses
- **Autonomy and authority** to implement EBP in their practice
- **Time away** from the bedside allocated to EBP activities

- **TRAINING**
- **Purposeful** applicable, hands-on training.
- **Additional** to nursing school knowledge
- **Tailored** to fit the nurses' specific learning needs

- **EQUIPPING**
- Ensuring **access** to computers, library resources and **mentors.**
- **Communication** re; what resources are available and how to access them.

- **LEADERSHIP DEVELOPMENT**
- Leaders setting the **EBP culture**; asking questions, allocating resources, and implementation support.
- Development and integration of EBP **mentors**.

Readiness: prepared mentally and/or physically for some experience or action (EBP). Prepared for immediate us".

(Merriam and Webster dictionary, 2018).

So what have we come to know?

What Matters?

- **A vision** for an evidence-based enterprise **Organizational culture**
- **Readiness** for EBP
- **Leadership**
- **Strategic planning**
- **EBP competence** (knowledge skill and attitude)
- Organizational **infrastructures**
- A tested **EBP Model**
- **Resources** (people, time, mentors)
- Connecting **EBP, quality and research**
- **Persistence**
- **Courage**

What doesn't matter?

- Size
- Complexity
- Academic affiliation
- Prestige
- Location
- "Status"

Vision

Clear vision

Think success

…at the outset

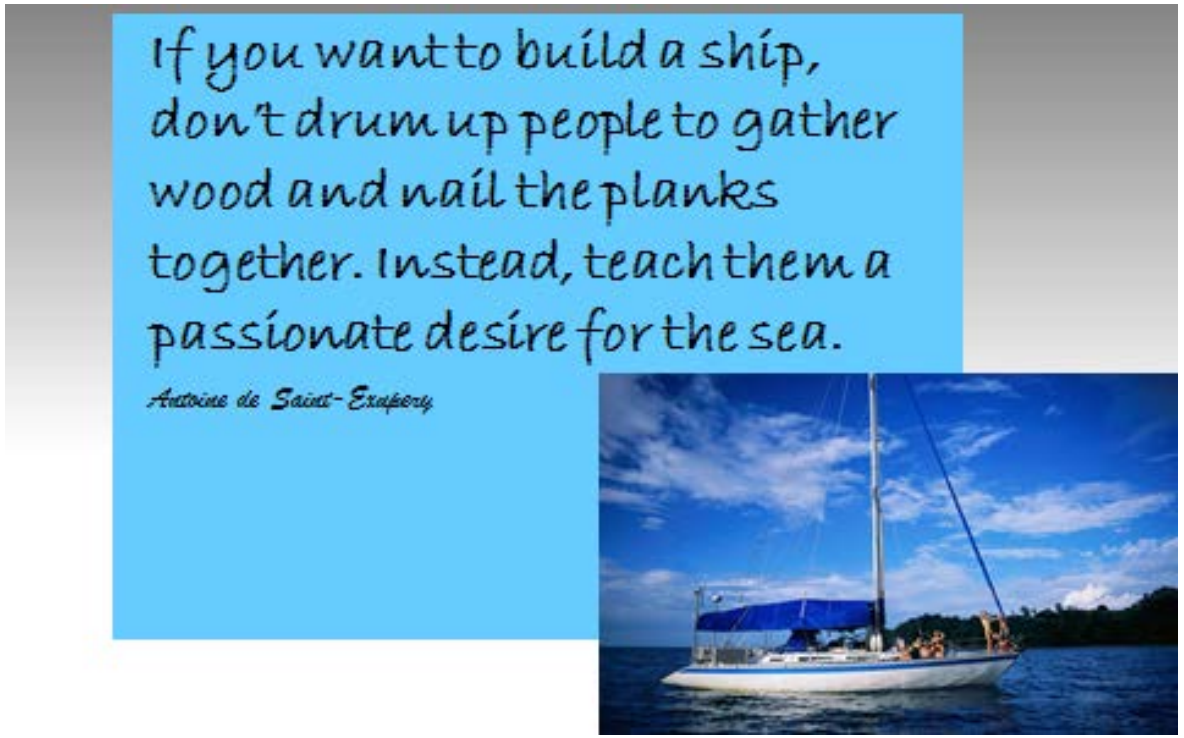
Rewards are as Big as Your Dreams

Thinking little goals yields little achievements.

Thinking big goals yields big achievements!

You must dream it, before you can do it!

Get people inspired!



It's not what you do...
it's why you do it. Simon Sinek

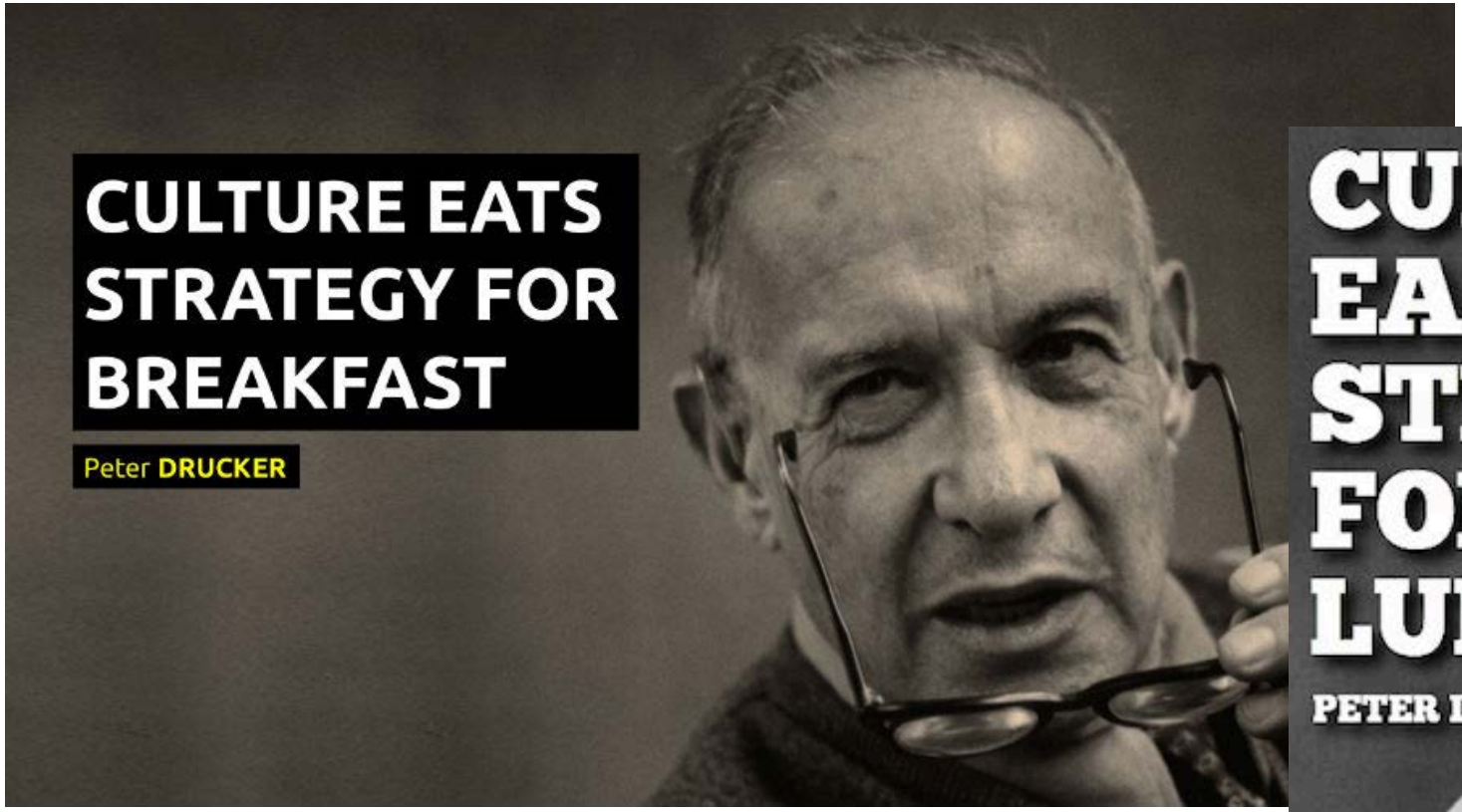
Critical responsibilities that leaders must ensure

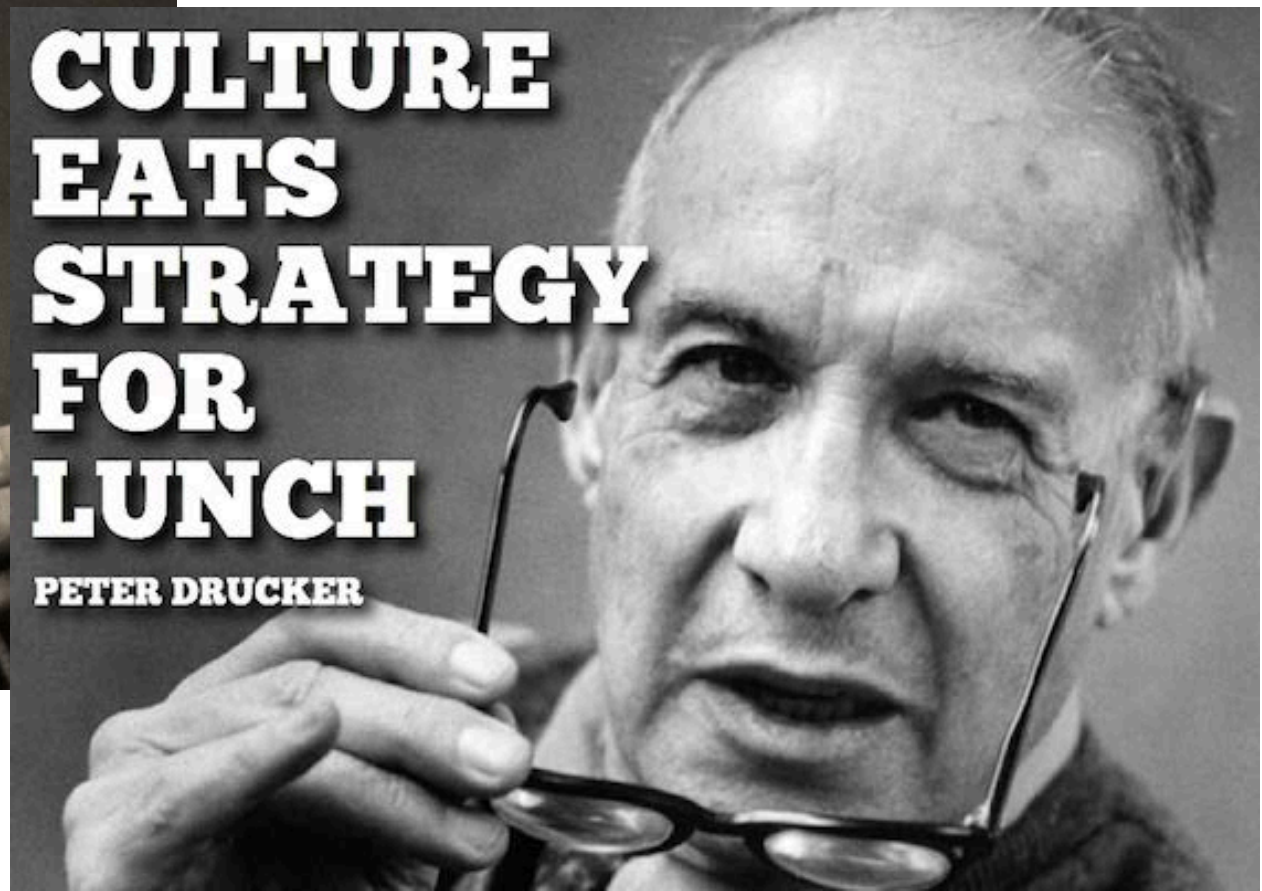
…in an EBP environment:

- Support
- Encourage
- Give “voice” to clinicians
- Negotiate work conditions
- Provide education
- Role model
- Raise the call to a common purpose/continuous commitment
- Keep momentum going


Engaged leadership
The Boss

And…


CULTURE EATS STRATEGY FOR BREAKFAST
Peter DRUCKER


CULTURE EATS STRATEGY FOR LUNCH
PETER DRUCKER

Strategic Planning

Identify your **strengths and barriers** to implementation of EBP.

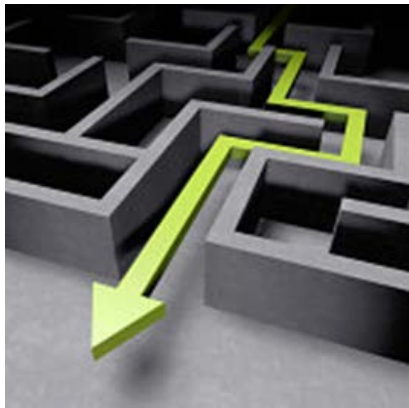
Set **SMART goals** based on your vision

and your institution's vision.

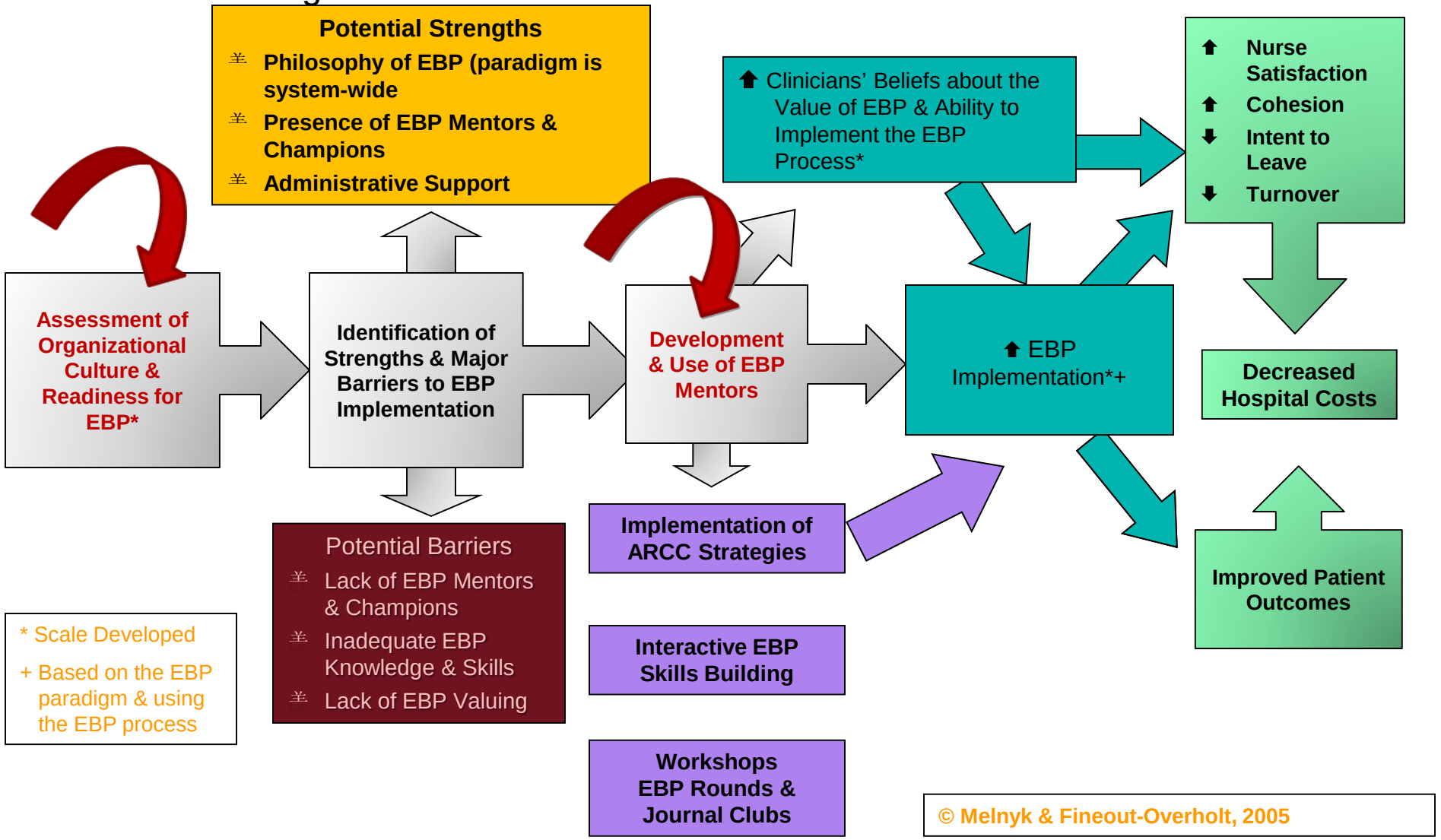
What are your **immediate** goals? **long-term** goals?

WRITE IT DOWN…set a timeline.

How will you **measure** your success?



The ARCC© Model: Select a Model THAT WORKS (!).... to Advance EBP in Your Organization



What's the Connection?

Mentors impact Beliefs

Two Types of Beliefs

1. Belief in **the value of EBP**
2. Belief that **we can do EBP here**

Beliefs drive Implementation

Strategic Investment

In order to have a RETURN ON INVESTMENT...

There must be an INVESTMENT to begin with!

Maximizing *Return on Investment*

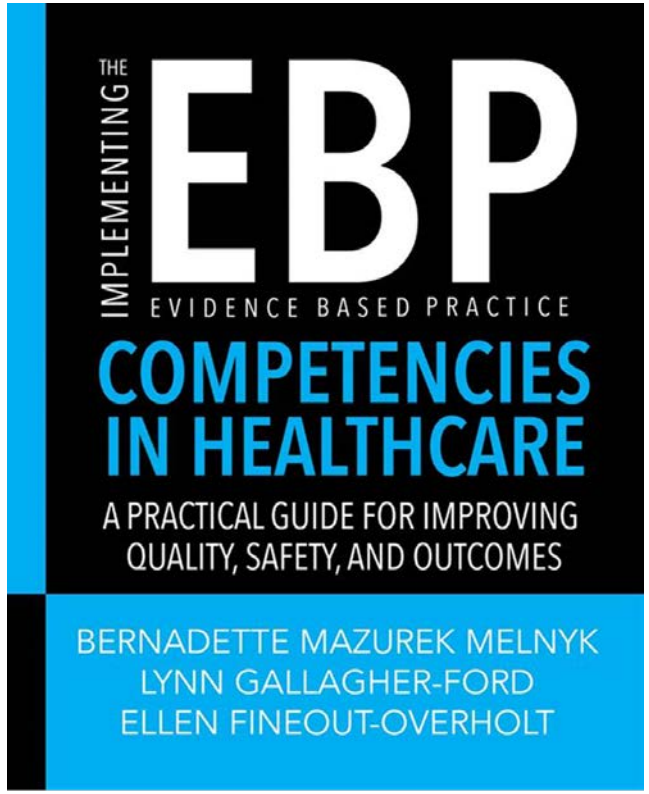
Minimizing *Risk of Ignoring*

"How will we ever find a way to do this?"

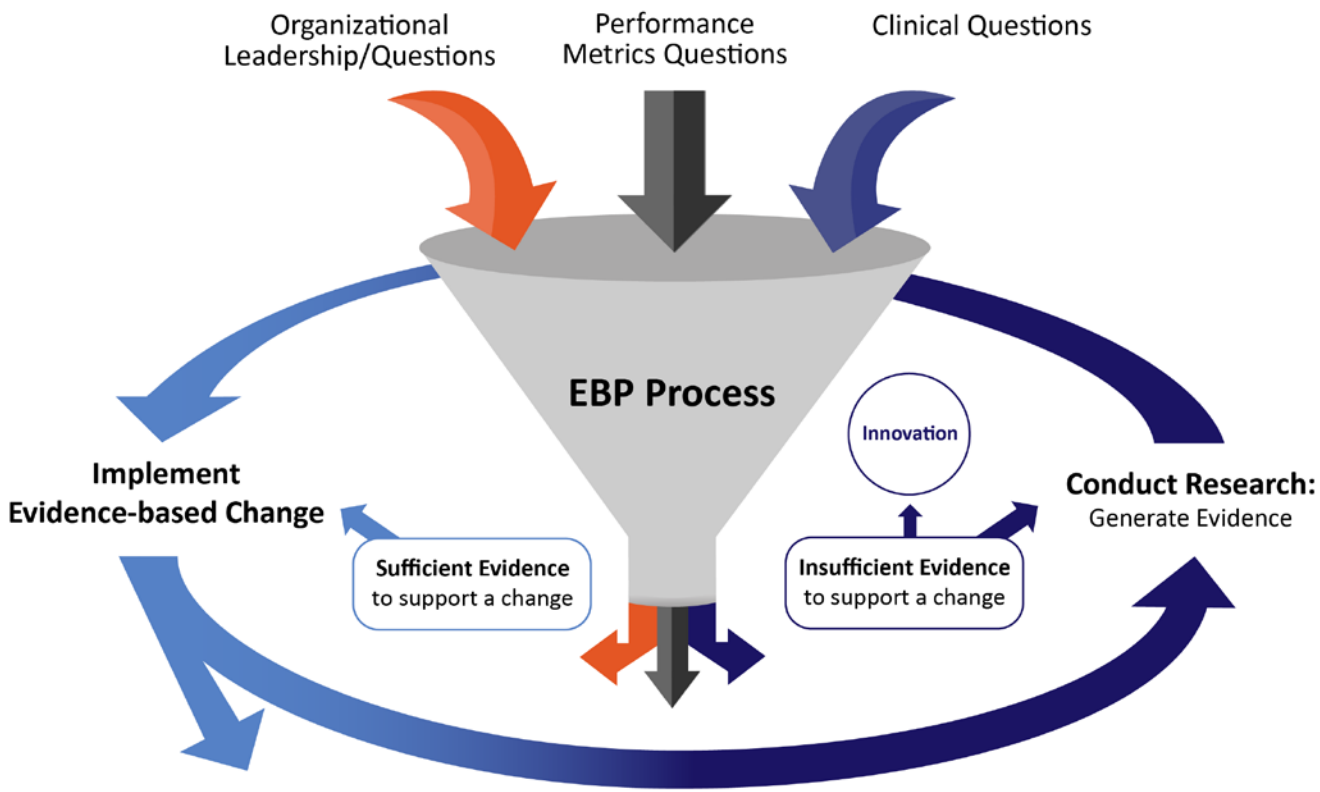
"Where will we ever find the time to do this?"

Integrate the Competencies

- **Job Descriptions**
- **Clinical Ladders**
- **Interdisciplinary Policy and Procedure Committees**
- **Shared Governance**
- **Onboarding/Orientation**
- **Residency Programs**
- **Journal Clubs**
- **Interdisciplinary Rounds**



EBP, Research, Innovation, and QI Alignment Model

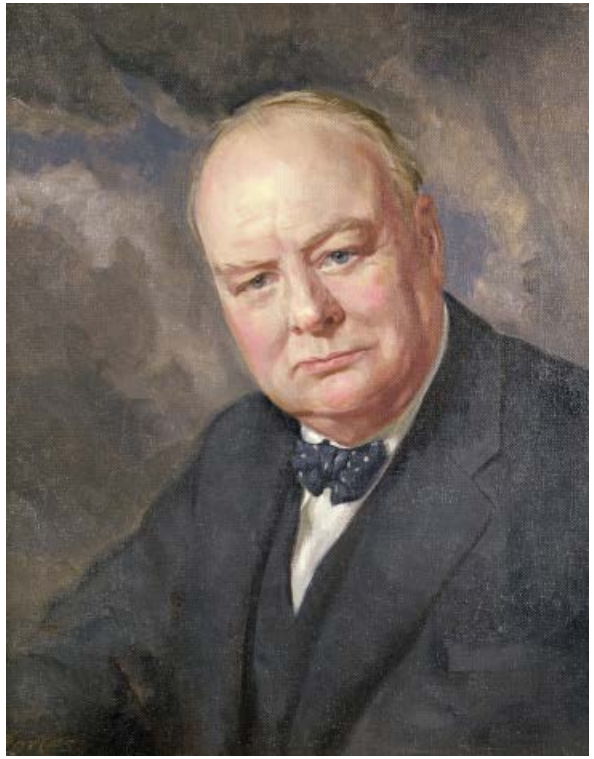


Monitor and Sustain Evidence-based Change through **QI Process**

Persistence

NEVER, NEVER, NEVER, NEVER, NEVER, NEVER, NEVER, QUIT!

Winston Churchill



You cannot discover new oceans unless you have the courage to lose sight of the shore.

You must risk.

Educate about EBP; we never learned it in school!

Leverage your new grads!
They KNOW EBP!

THE OHIO STATE UNIVERSITY
COLLEGE OF NURSING

A CTEP IMMERSION WORKSHOP

Evidence-based Practice

Making it a reality in your organization

A transformational journey to improve healthcare quality and patient outcomes

Our 2017 workshops: July 10-14, October 2-6 in Columbus, OH

This unique program provides a "deep-dive" immersion into evidence-based practice. Participants will learn the step-by-step evidence-based practice process as well as effective strategies for integrating EBP in clinical and academic organizations of any size or level of complexity. Participants will return from this experience with an action plan for implementing and sustaining evidence-based practice changes and transforming their organizational culture. Bring your practice partner to collaborate on improved outcomes.

Participants can choose one of three specialty tracks: 1. Mentor 2. Leader 3. Faculty
The half-day specialty tracks in the 5-day EBP immersion program include content specifically focused on responsibilities of individuals in these unique roles.

In addition to five days of intensive education in EBP and 37 contact hours of continuing education for nurses, participants will have access to The Ohio State University library resources for one year, lifetime access to monthly EBP webinars, EBP listserv membership, access to CTEP EBP resources and an opportunity for networking with like-minded individuals.

If you are looking for a single program to ignite and sustain the evidence-based practice shift in your organization..... this is it!

CTEP Center for Transdisciplinary Evidence-based Practice

CTEP is your partner in achieving and sustaining improved healthcare quality and patient outcomes.

ctep-ebp.com

THE OHIO STATE UNIVERSITY
COLLEGE OF NURSING

A CTEP IMMERSION WORKSHOP

Monday	Tuesday	Wednesday	Thursday	Friday
Introduction to EBP	Review of research methods	Critical appraisal: systematic reviews and facilitated breakout sessions	Communications styles (DiSC)	Dissemination of EBP projects
Making the case for EBP	Effective searching for evidence	Evaluation and synthesis of evidence	**Mentor Track**	Dreaming past the possible
Assessing your organizational culture	Search strategies and techniques	Mentored EBP project work	**Leader Track**	Presentation and awards ceremony
Clinical Inquiry and PICOT questions	Mentored EBP project work	Managing your bibliography	**Faculty Track**	Closing remarks
Mentored EBP project work	Introduction to critical appraisal of evidence	Integrating evidence into decision making	Creating a vision for EBP	
		Understanding, measuring, and evaluating outcomes	Putting it all together	
			Mentored EBP project work	

Registration fee for this workshop is $2,100 per participant; $1,850 per participant for groups of three or more. Fee includes daily light breakfast, lunch and snacks. No refunds can be given; payment may be applied to a different immersion date within one year.

For further information or questions about this workshop, accommodations, or pricing, contact Lynn Ellingsworth, CTEP program manager, at ellingsworth.1@osu.edu or Lynn Gallagher-Ford, CTEP director, at gallagher-ford.1@osu.edu.

To register, please visit ctep-ebp.com.

Please note: To participate in this workshop, you must bring a laptop computer (and we suggest a separate mouse) with Windows XP or higher, or Mac 10.5 or higher.

Expert EBP faculty to include (upon availability):

Bernadette Mazurek Melnyk, PhD, RN, CPNP/PMHNP, FNAP, FAAN, associate vice president for health promotion, university chief wellness officer, and dean of The Ohio State University College of Nursing

Lynn Gallagher-Ford, PhD, RN, DPFNAP, NE-BC, director of the Center for Transdisciplinary Evidence-based Practice, and clinical associate professor, The Ohio State University College of Nursing

Cindy Zellefrow, DNP, MSEd, RN, LSN, APHN-BC, assistant director of the Center for Transdisciplinary Evidence-based Practice, and assistant professor of practice, The Ohio State University College of Nursing

CTEP Center for Transdisciplinary Evidence-based Practice

The Ohio State University College of Nursing

760 Kinnear Rd.
1st floor
Columbus, OH 43212

614-688-1175
ctep-ebp.com

This program will award 37 contact hours of continuing education for nurses.

Continuing Education Disclosure Statement

The Ohio State University College of Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The Nurse Planner and Planning Committee have no conflicts of interest to disclose.

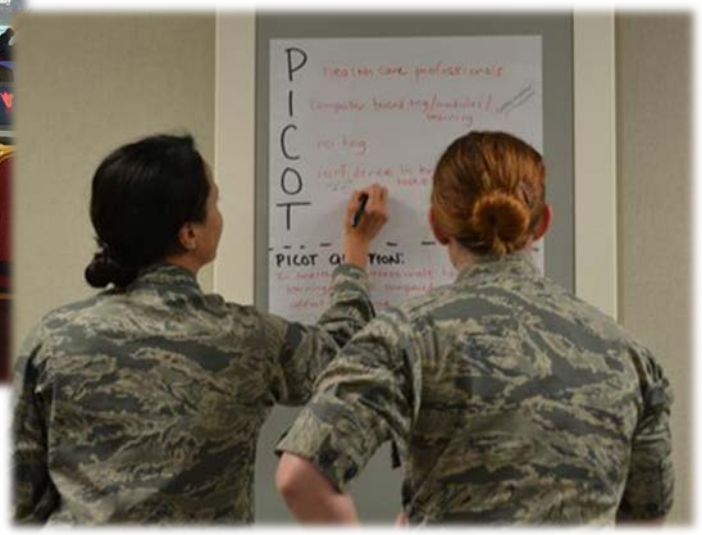
Drs. Lynn Gallagher-Ford and Bernadette Mazurek Melnyk are nationally known experts in EBP and co-authors of books about EBP. The content they present will be free from bias.

There was no commercial support or sponsorship for development of this program.

To successfully complete this program and receive contact hours, you must attend at least 80 percent of the course.

Our CTEP partners:

The Ohio State University Wexner Medical Center
The James
The Ohio State University Wexner Medical Center
Nationwide Children's


PICOT

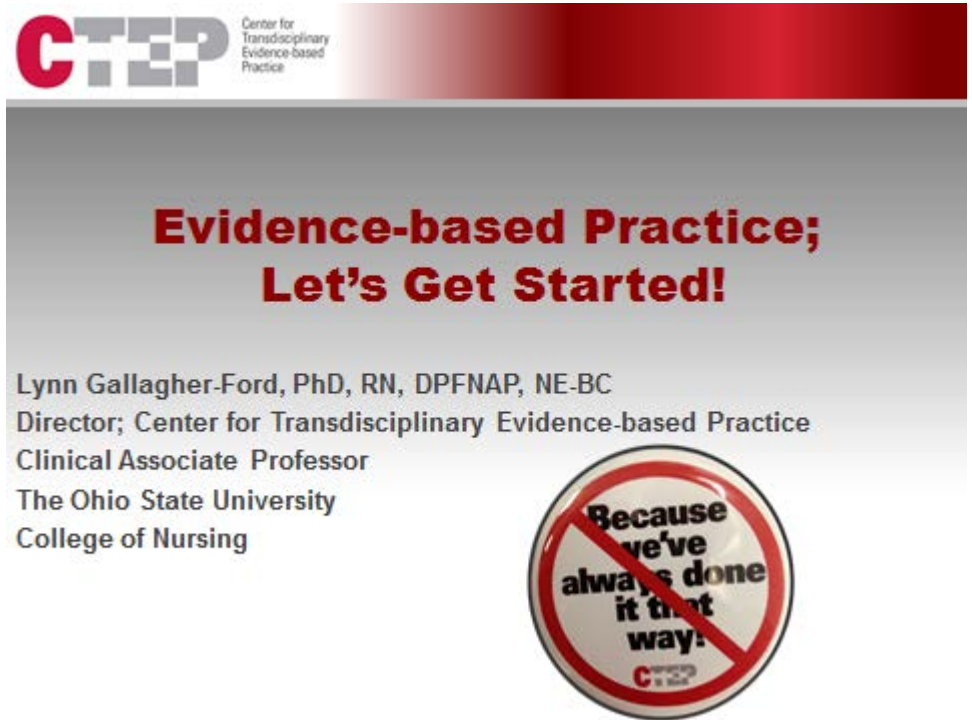
Once you have EBP competence built, then how do you grow and sustain it?

Onboarding/Orientation/Residency Programs

RNs

APNs

Leadership



EVERY Job Description and Performance Appraisal

RNs: pull EBP language directly from the competencies!

"questions," "describes," "participates in,"
"searches," "collects," "integrates,"
"implements," "supports," disseminates"

APNs and Leaders: pull EBP language directly from the competencies!

"systematically conducts,"
"critically appraises,"
"mentors," "leads"

Create Supportive Infrastructure for EBP

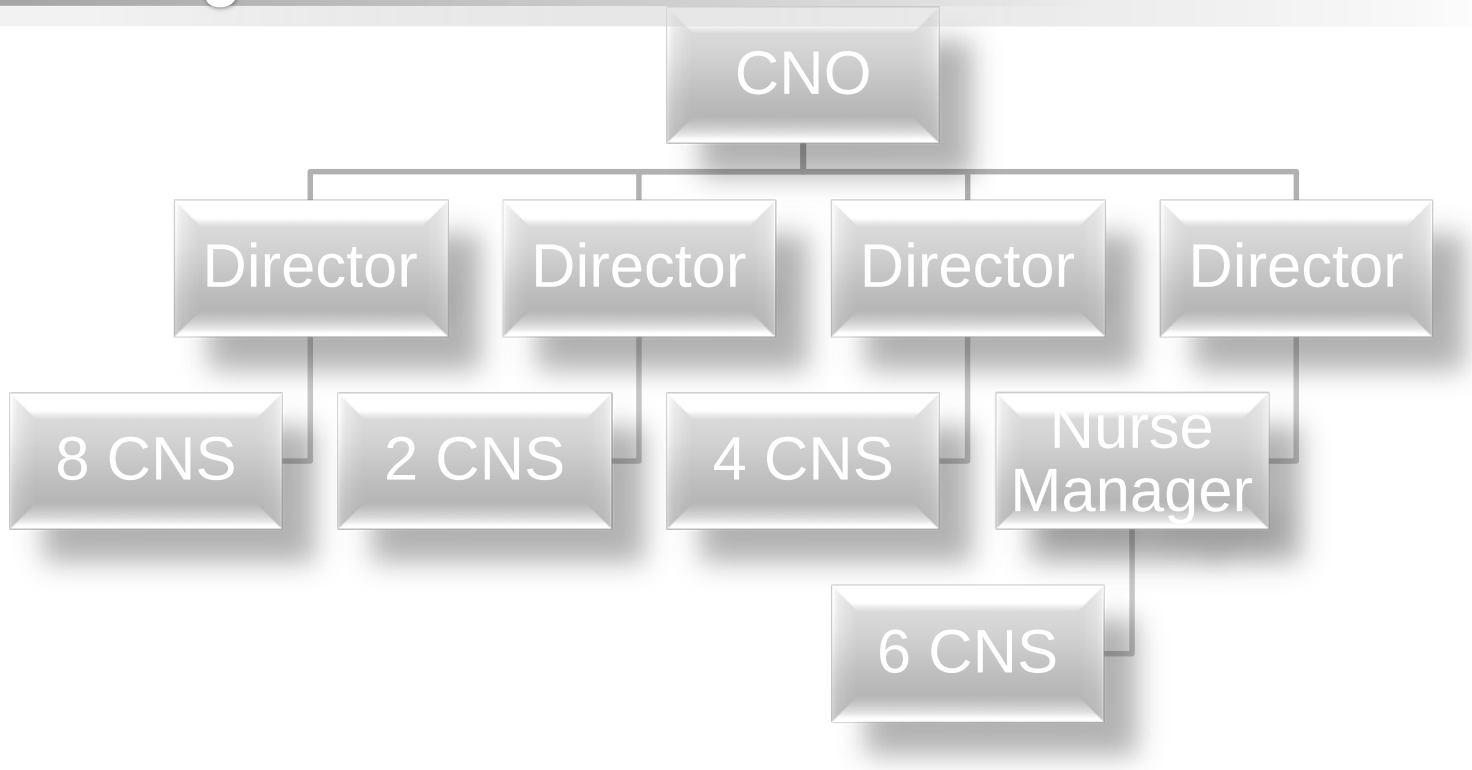
Organizational Alignment

Realigned CNS's in the Health System to report to Health System Nursing Administration

- Direct report to director of Nursing Quality
- Indirect reporting structure to Nursing EBP
- Job description, evaluation, explicit expectations

- Shared vision for EBP
- Central reporting structure for EBP work
- Revised CNS Role to include "EBP Mentor"
- Revised CNS Job Description to include EBP deliverables.

Organizational Structure Before Realignment



EBP, Research and Quality Director Job Description

JOB KNOWLEDGE: Service Areas - Demonstrates and utilizes skills and knowledge to effectively direct services in areas of responsibility.

•Educates and mentors staff and leadership teams in EBP, research and quality methodologies.

•Role models EBP in daily practice.

•Assures integration of EBP, research, and quality processes across disciplines and the organization.

LEADING PEOPLE- Recruits, hires, ……. employees to provide quality service in a manner consistent with XXX values.

•Assembles effective EBP, research, and quality teams. Monitors effectiveness of teams and provides data supported outcomes of teams' work.

•Provides a healthy work environment that supports best (evidence-based) practices, best patient outcomes and employee satisfaction .

FINANCIAL MANAGEMENT - Develops and controls department budget within xxx percent of budget standards.

•Assures that all EBP, research and quality projects include a business plan and estimated ROI prior to launch.

Opportunities to Integrate EBP Competencies

Clinical Ladders

RNs
APNs
Other clinicians
Other employees
Leadership

Clinical Ladder Program

The Clinical Ladder program at XXX Medical Center recognizes and rewards staff nurses *for clinical expertise in delivering direct care* to patients. The participating RN is *recognized with a promotion* from Staff Nurse II to Staff Nurse III or IV and an *increase in base salary*. The Clinical Ladder program is a *voluntary program* in which the nurse *demonstrates expertise* in the areas of *clinical management, educational activities, evidence-based practice, and research*.

Examples of activities in these areas include:

- Serving on unit and hospital committees
- Demonstrating excellent patient care in complex situations
- Providing education to other healthcare providers
- Precepting other staff members
- Obtaining continuing education credits
- Participating in quality improvement initiatives
- Evaluating and utilizing nursing research
- Achieving specialty certification
- **Participating in evidence-based practice projects**

Policy and Procedure Committees

- Transdisciplinary Opportunity

Shared Governance Councils

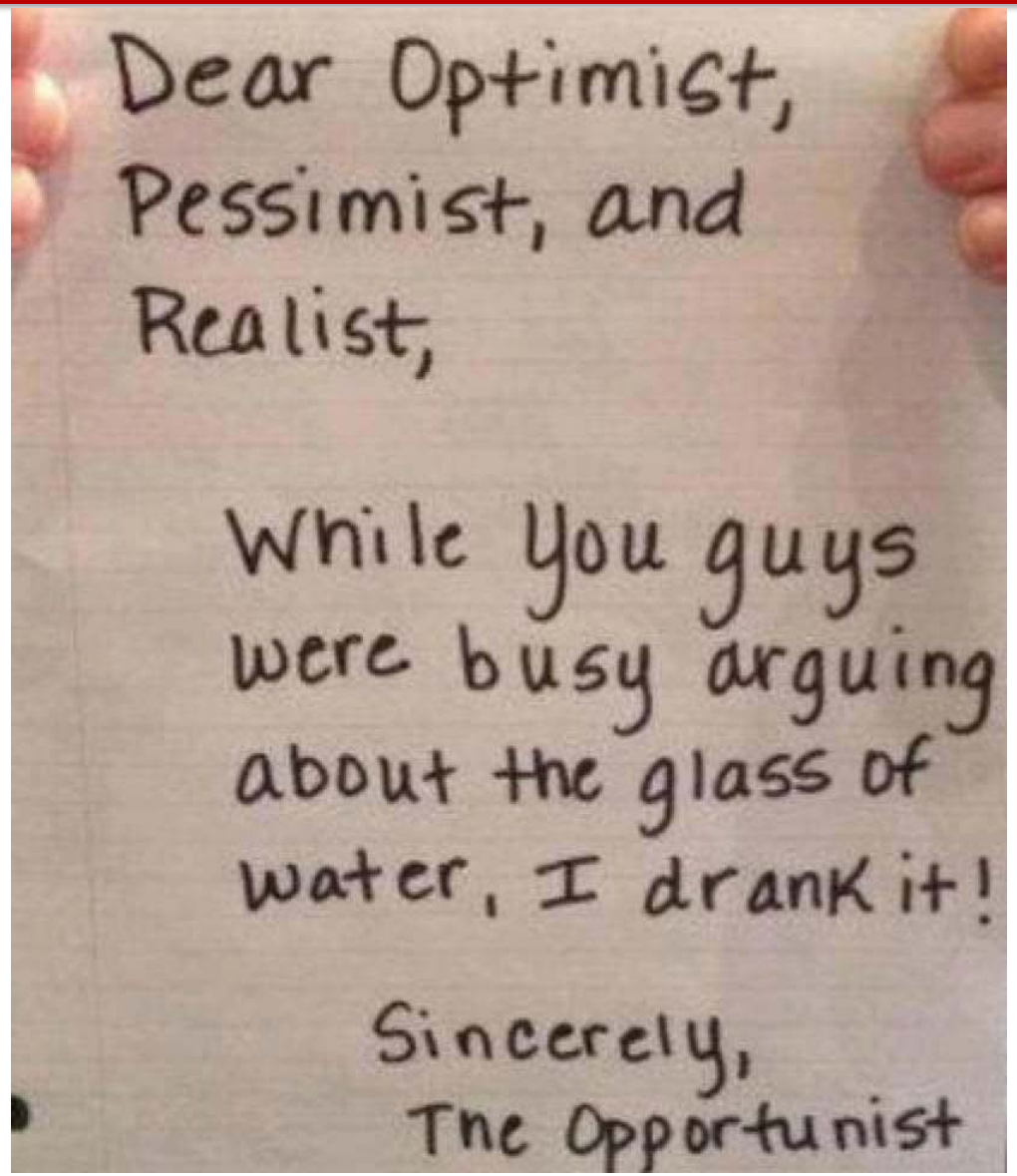
"A dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving quality of care, safety, and enhancing work life." Vanderbilt

- Research and EBP Council
- Quality Council
- Clinical Practice Council
- XYZ Council

EBP expectations for….

All members? Chairs Only? Administrative Facilitators?

WHAT WILL WE DO?



Outcomes of Implementing the ARCC© Model at Washington Hospital Healthcare System

- Early ambulation in the ICU resulted in a reduction in ventilator days from 11.6 to 8.9 days and no VAP
- Pressure ulcer rates were reduced from 6.07% to .62% on a medical-surgical unit
- Education of CHF patients led to a 14.7% reduction in hospital readmissions
- 75% of parents perceived the overall quality of care as excellent after implementation of family centered care compared to 22.2% pre-implementation

Building a relationship…

Sustainability… Cohort 1; examples of outcomes:

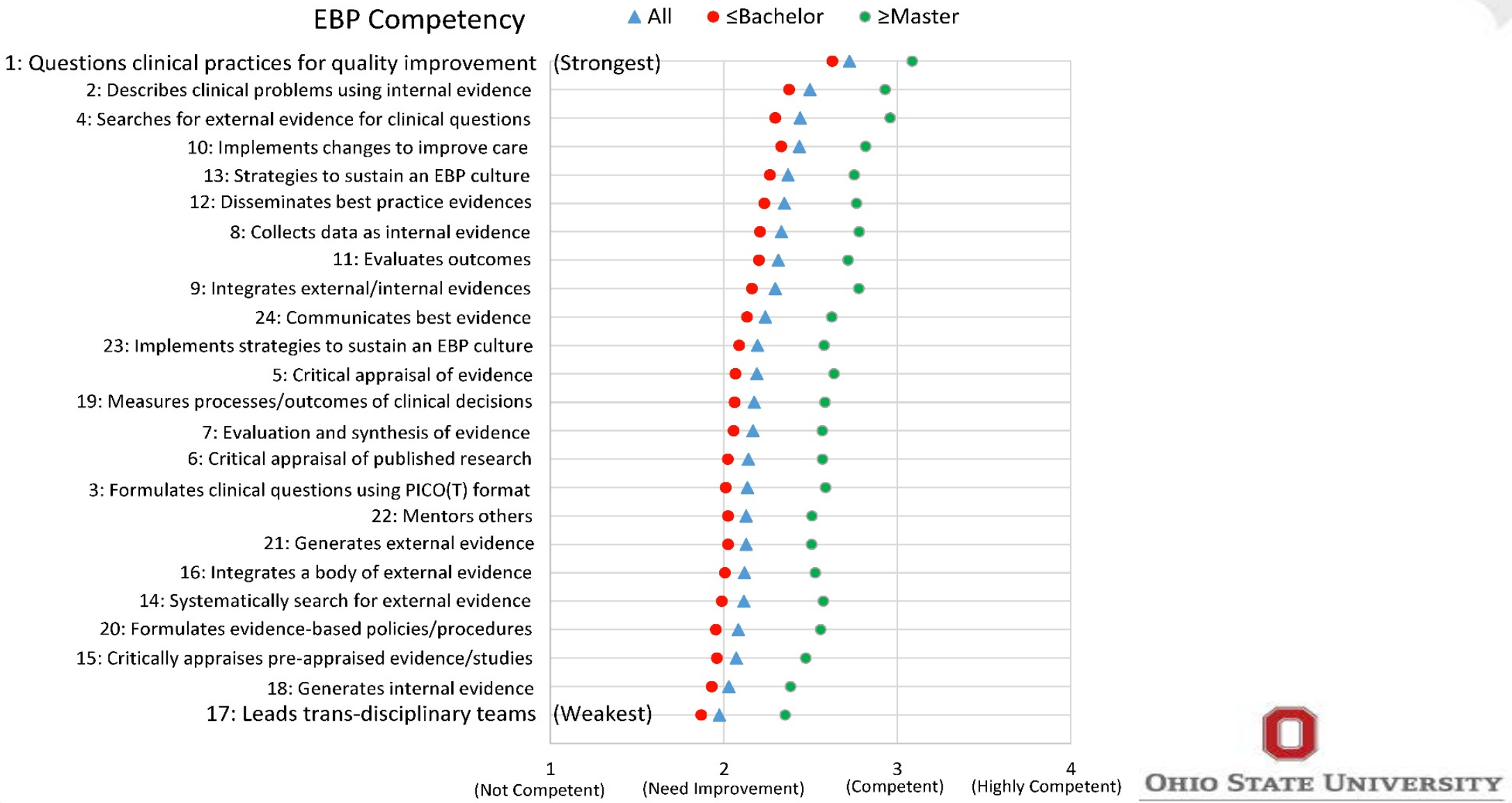
Structures built:

- Added EBP language into the **Department of Nursing Quality and Safety Plan**
- Integrated EBP language into the **Clinical Nurse Job Descriptions**
- Added EBP structure into the **NEW RN Graduate Nurse Residency Program**
- Integrated EBP into **Clinical Ladder progression** NCARE© CN III / CN IV

Projects initiatives implemented:

- Restructured the **Falls Prevention program** to include all employees in all location (valets, front desk, gift shop, environmental services and all clinicians) based on evidence
- Implemented a **perioperative initiative to mitigate pressure ulcer risk** across the perioperative period
- Revamped the **entire Preceptor Program** based on evidence
- Revised **Peer Review** program based on evidence

State of Self-reported EBP Competencies by Nurses Across the United States (N = 2075)



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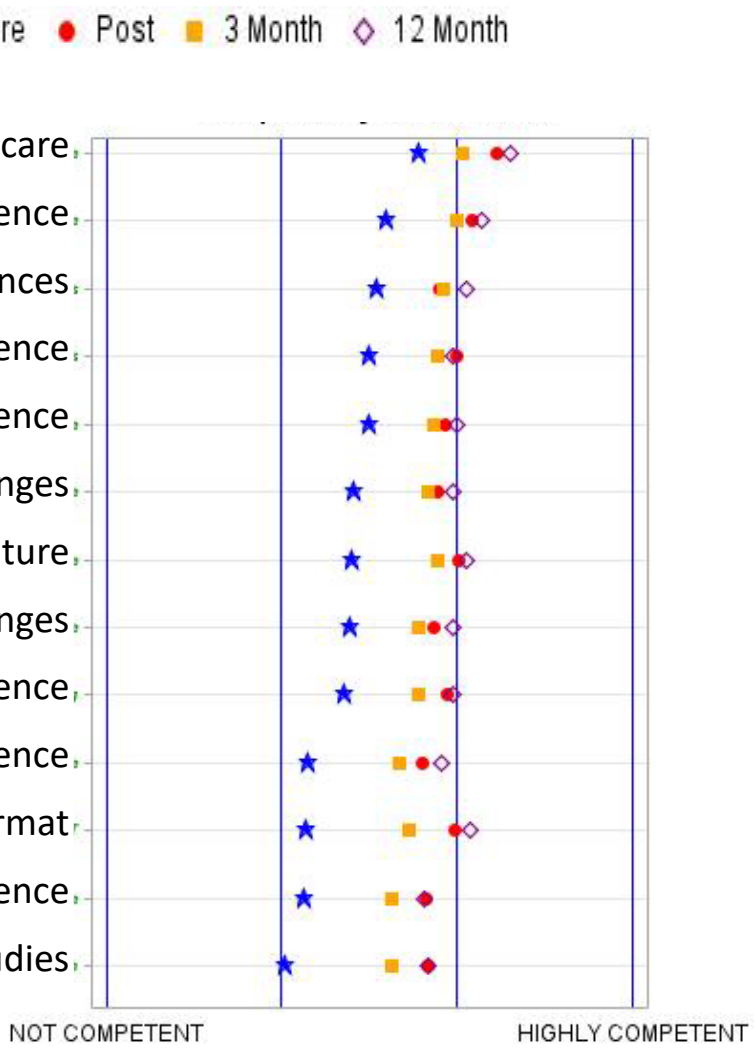
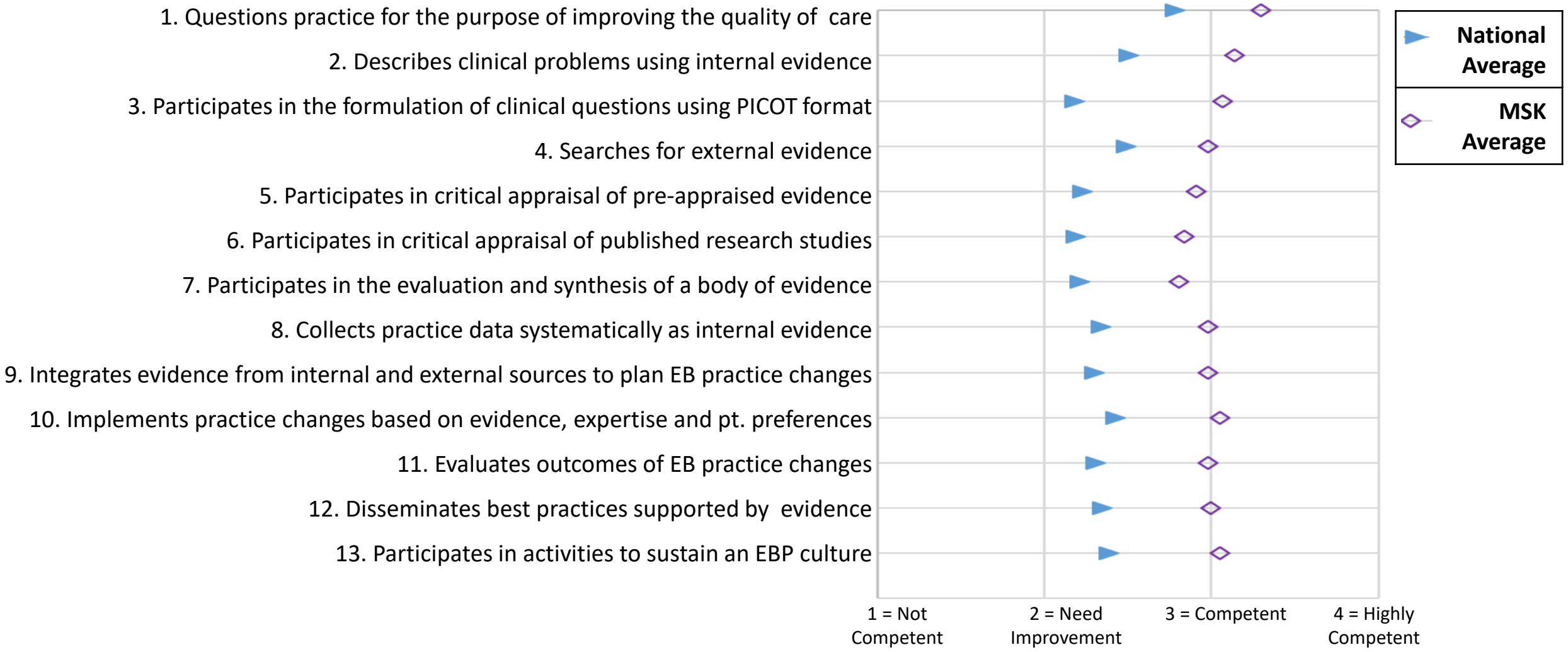
MSK EBP RN Competencies



EBP RN Competencies: MSK vs. National Study Data



Snowball effect; Fuld synergies!

This is where live!

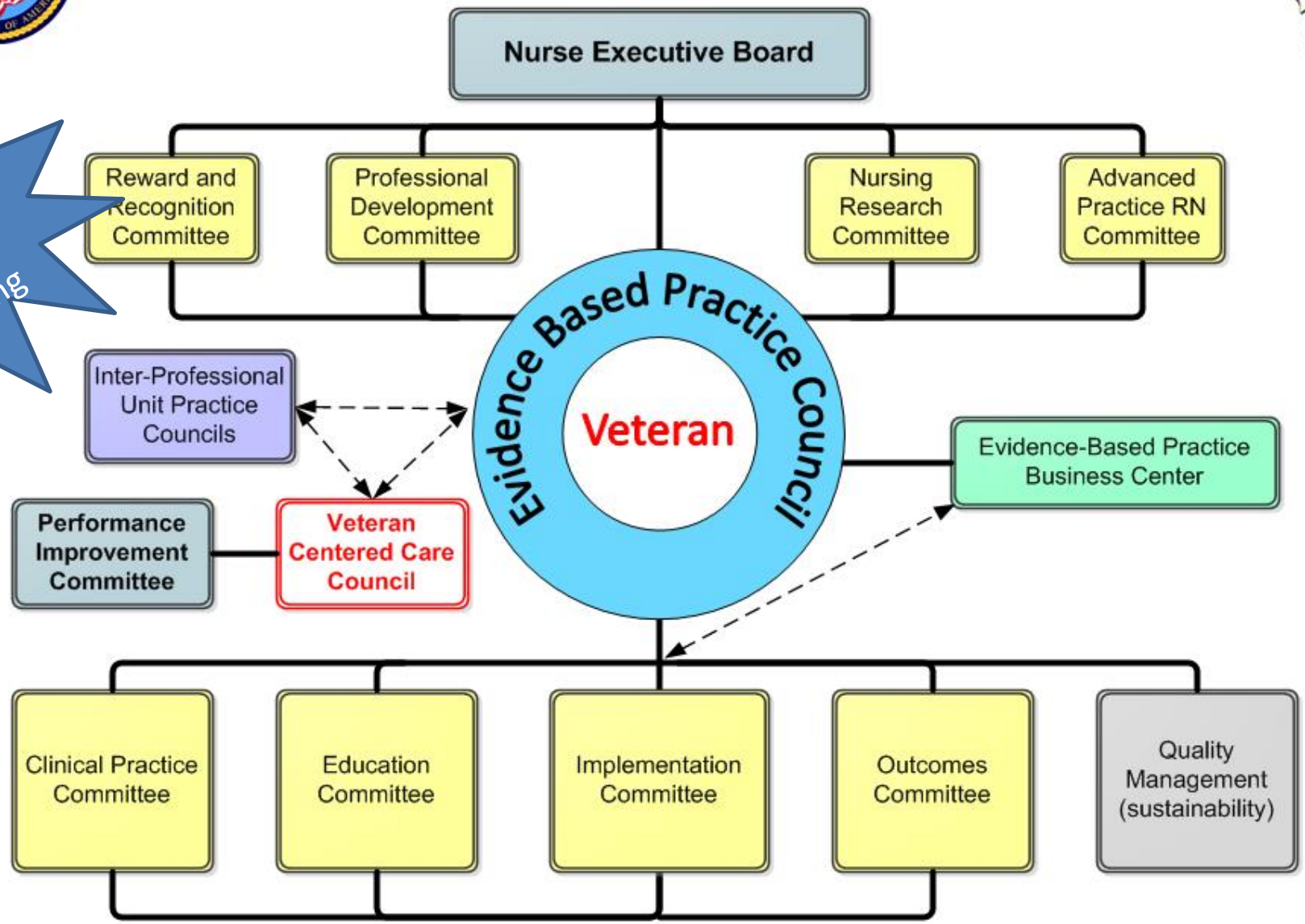
This is what I do!

This is what happens!

Evidence-Based Practice Council Organizational Chart

Relationship Based Care philosophy is the theoretical underpinning for all council and committee work.

USAF experience, Fuld networking



Key: Solid line = reporting relationship; Dotted line = a collaborative relationship

This diagram is confidential for the use by the Dayton VA only.

Updated 01/05/18 Gorsuch, P.; Sampsel, D.; Slonaker, P.; Worley, J.; James,E.

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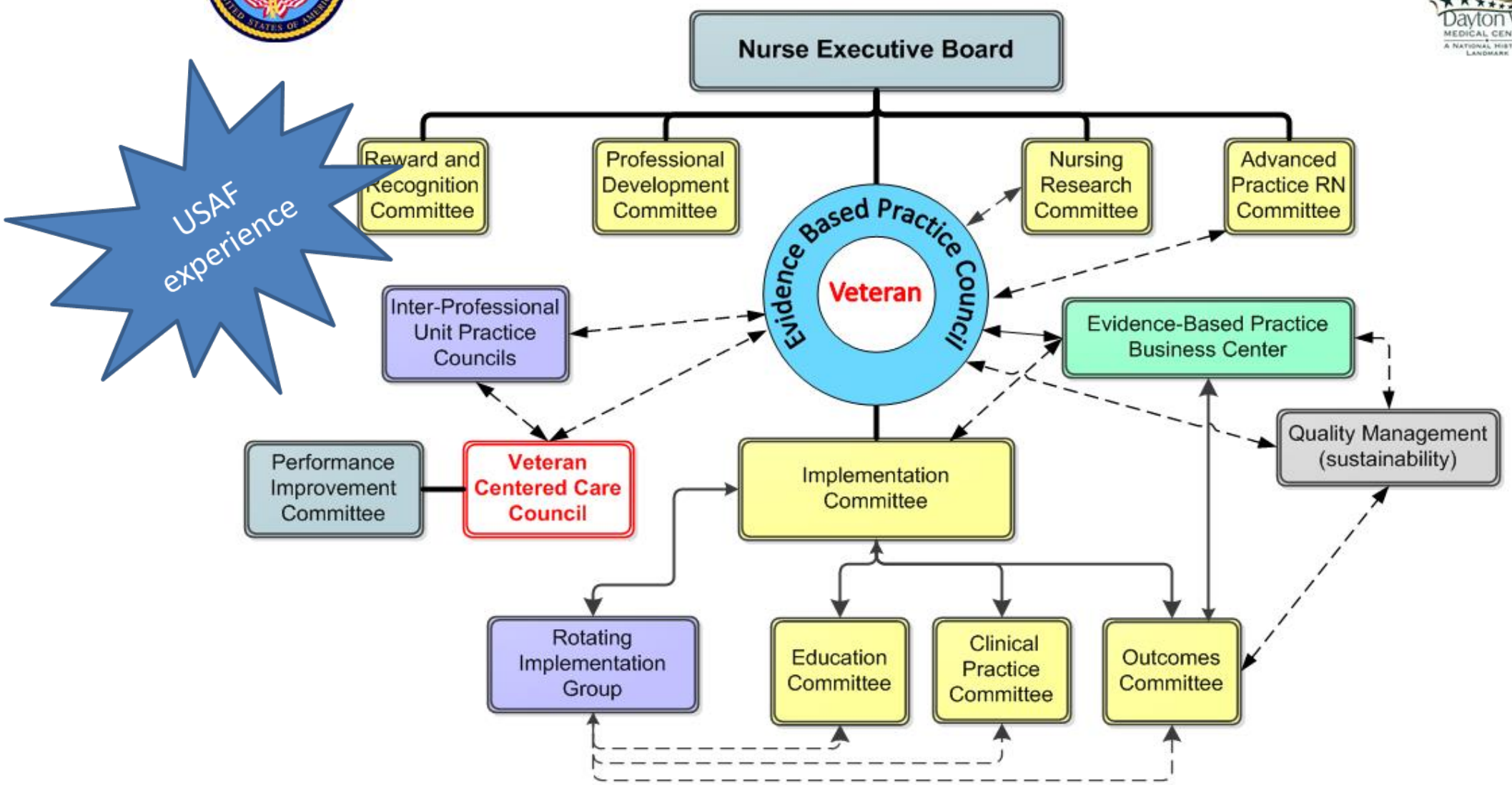
Evidence-Based Practice Implementation Structure

Relationship Based Care philosophy is the theoretical underpinning for all council and committee work.



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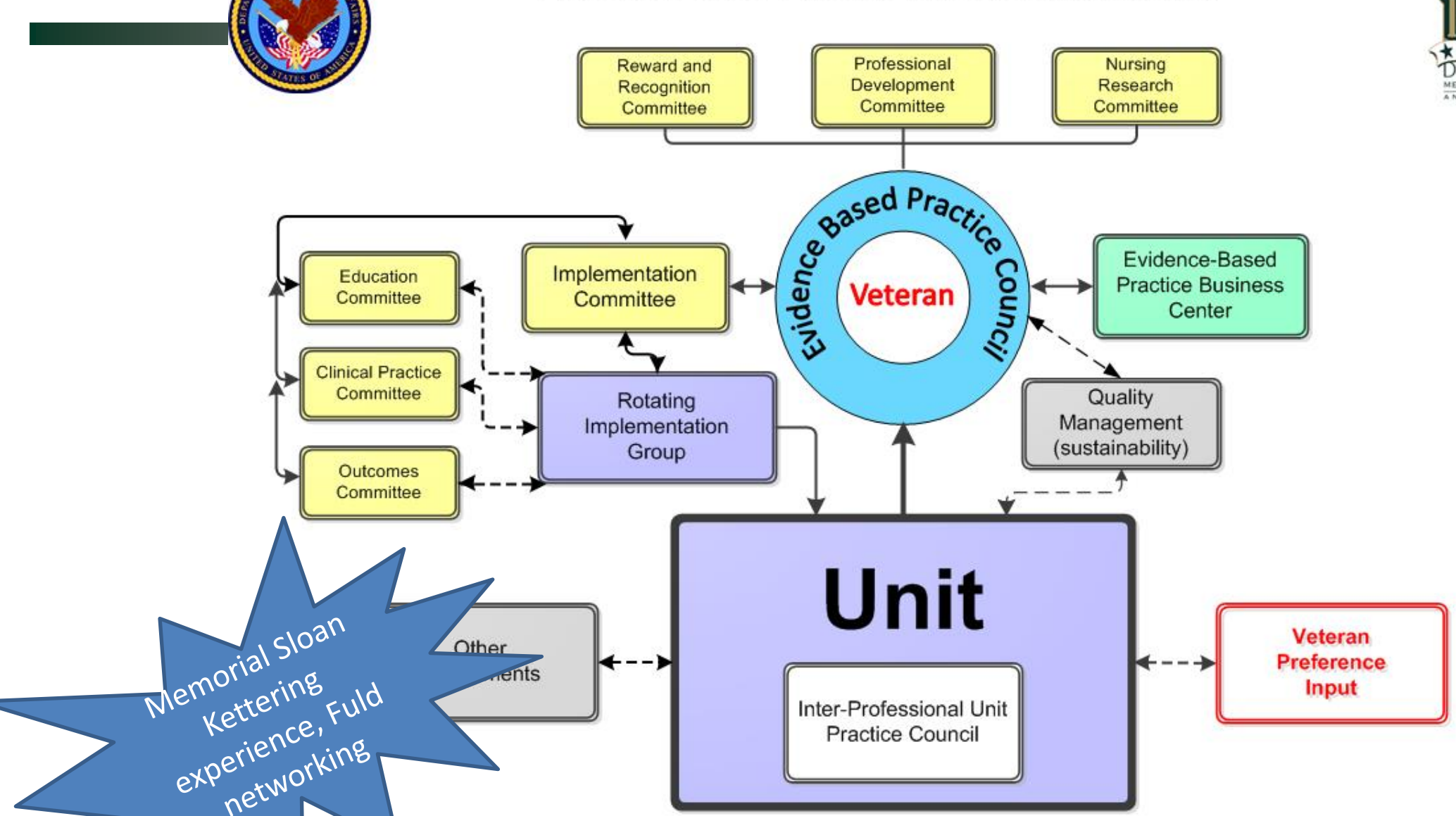
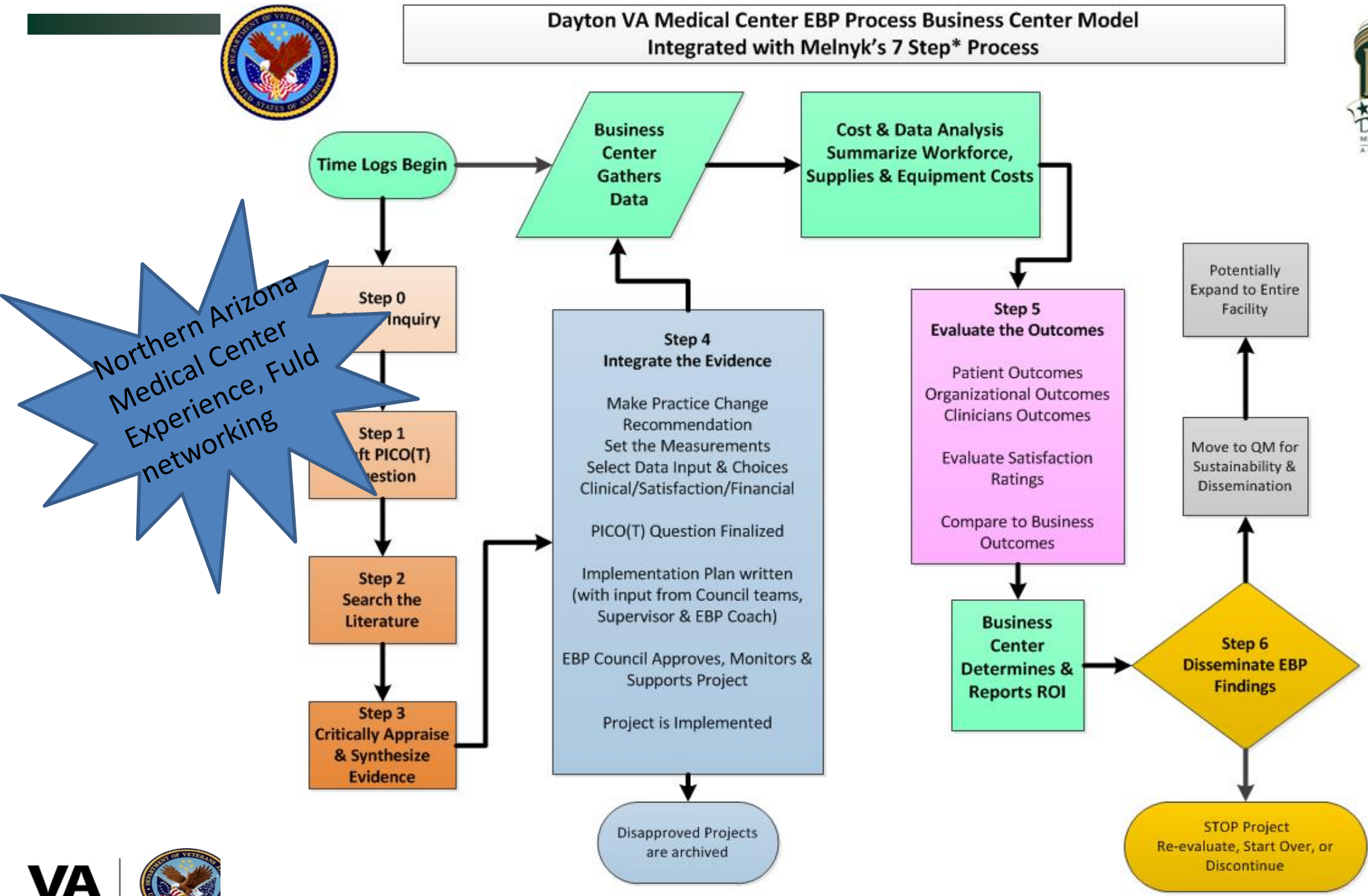


Dayton VA Medical Center EBP Process Business Center Model Integrated with Melnyk's 7 Step* Process



Northern Arizona Medical Center Experience, Fuld networking

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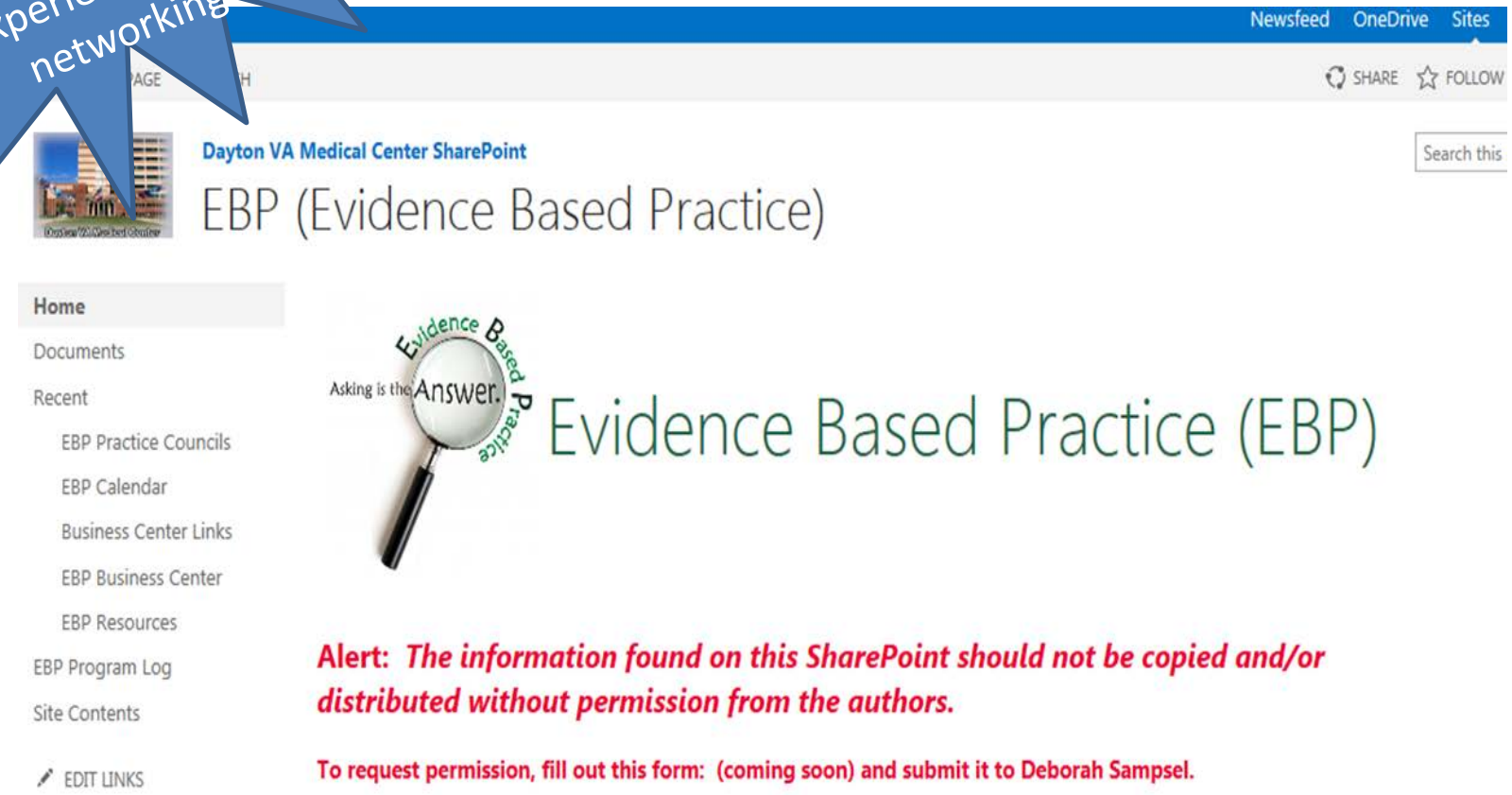
*Reference 7 Steps: Melnyk, B. & Fineout-Overholt 2011, Evidence-Based Practice in Nursing and Healthcare, Walters-Klovwer

Children's Hospital of Colorado experience, Fuld networking

Evidence-Based Practice SharePoint Site



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So, the work goes on.
We can do this!

See you next year!

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