

The Best Practice Spotlight Organizations (BPSO) Program Experience in Australia

Experiencia en el programa: Las mejores prácticas de las organizaciones más destacadas (BPSO) en Australia

Experiência no programa: Melhores práticas de organizações líderes (BPSO) na Austrália

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Abstract

Introduction: The Registered Nurses' Association of Ontario's flagship Best Practice Spotlight Organization® Program is scaling up implementation around the globe. The Australian Nursing and Midwifery Federation has successfully partnered with the Registered Nurses' Association of Ontario's to become a Best Practice Spotlight Organization Host, and establish an evidence-based culture in South Australia. Australian Nursing and Midwifery Federation is the largest professional organisation and trade union for nurses, midwives and assistants in nursing in Australia with a commitment to high standards of professional practice, effective bargaining and industrial representation of members as well as a progressive, social justice based approach to policy issues facing the health system (Australian Nursing and Midwifery Federation 2017). **Objective:** Reflect on the experience of Australian Nursing and Midwifery Federation in

implementing the Best Practice Spotlight Organization Program in nursing in South Australia. **Methodology:** To describe the process of scaling up the Registered Nurses' Association of Ontario's Best Practice Guidelines program in South Australia through its Best Practice Spotlight Organizations world renowned feature, barriers and opportunities to its uptake and its evaluation. **Conclusions:** Evaluation of the Best Practice Spotlight Organizations program demonstrates the value of practice reforms, which were implemented and improved outcomes for patients/clients, improved professional satisfaction and capacity, and created cost efficiencies in the pilot sites. [Hurley J, Dabars E, Bonner R. *The Best Practice Spotlight Organizations (BPSO) Program Experience in Australia. MedUNAB 2017; 20(2): 215-223*]

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Resumen

Introducción: La asociación de enfermeras registradas de Ontario y su programa principal de mejores prácticas de las organizaciones más destacadas está ampliando su implementación alrededor del mundo. La Federación Australiana de Enfermería y Obstetricia se ha asociado exitosamente con la asociación de enfermeras registradas de Ontario para convertirse en anfitriona de Las mejores prácticas de las organizaciones más destacadas y establecer una cultura basada en la evidencia en Australia del Sur. Federación Australiana de Enfermería y Obstetricia es el sindicato y la organización profesional más grande para enfermeras, parteras y asistentes en enfermería en Australia, con un compromiso con altos estándares de práctica profesional, negociación efectiva y representación industrial de sus miembros, así como un enfoque progresivo basado en la justicia social a los problemas políticos que enfrentan el sistema de salud (Federación Australiana de Enfermería y Obstetricia 2017). **Objetivo:** Reflexionar sobre la experiencia de la Federación Australiana de Enfermería y Obstetricia en la implementación del Programa Las mejores prácticas de las organizaciones más destacadas en enfermería en el sur de Australia. **Metodología:** Describir el proceso de escalamiento en el programa, Guía para las Buenas Prácticas de la asociación de enfermeras registradas de Ontario en el sur de Australia a través de las mejores prácticas de las organizaciones más destacadas y de renombre mundial, características, barreras y oportunidades para su adopción y su evaluación. **Conclusiones:** La evaluación del programa Las mejores prácticas de las organizaciones más destacadas demuestra el valor de las reformas en la práctica, las cuales fueron implementadas y los resultados para los pacientes/clientes mejoraron; al igual que la satisfacción y la capacidad profesional mejoraron, y la creación de eficiencias en los costos de los sitios piloto también. [Hurley J, Dabars E, Bonner R. Experiencia en el programa: Las mejores prácticas de las organizaciones más destacadas (BPSO) en Australia. *MedUNAB* 2017; 20(2): 215-223]

Palabras Clave: Guía de Práctica Clínica; Enfermería; Práctica Clínica Basada en la Evidencia; Programas; Enfermería Basada en la Evidencia.

Introduction

The Registered Nurses' Association of Ontario's (RNAO) flagship Best Practice Spotlight Organisation® (BPSO®) Program is scaling up implementation around the globe.

The Australian Nursing and Midwifery Federation (ANMF) is the largest professional organisation and trade union for nurses, midwives and assistants in nursing and has a commitment to fostering high standards of professional practice, effective bargaining and industrial representation of members as well as a progressive, social justice based approach to policy issues facing the health system (1).

ANMF (South Australia {SA} Branch) is a state (provincial) member of the national ANMF and is the largest union in the state. With over 20,000 members the ANMF (SA Branch) is the largest nursing and midwifery professional body in the

Resumo

Introdução: A associação de enfermeiras registradas de Ontário e seu principal programa de melhores práticas das principais organizações, está expandindo sua implementação em todo o mundo. A Federação Australiana de Enfermagem e Obstetrícia fez uma parceria de sucesso com a Registered Nurses Association of Ontario para sediar as melhores práticas das organizações líderes e estabelecer uma cultura baseada em evidências, no sul da Austrália. A Federação Australiana de Enfermagem e Obstetrícia é o sindicato e a maior organização profissional para enfermeiras, parteiras e assistentes de enfermagem na Austrália, com um compromisso de altos padrões de prática profissional, de negociação eficaz e representação Industrial de seus membros, bem como uma abordagem progressiva com base na justiça social para os problemas políticos que enfrenta o sistema de saúde (Federação Australiana de Enfermagem e Obstetrícia 2017). **Objetivo:** Refletir sobre a experiência da Federação Australiana de Enfermagem e Obstetrícia na implementação do Programa As melhores práticas das mais destacadas organizações de enfermagem no sul da Austrália. **Metodologia:** Descrever o processo de encaminhamento no programa, Guia de Boas Práticas da Associação de Enfermeiras Registradas de Ontário, na Austrália do Sul, através das melhores práticas das organizações, líderes e de renome mundial, suas características barreiras e oportunidades, para sua adoção e avaliação. **Conclusões:** A avaliação do programa, As melhores práticas das organizações mais destacadas, demonstra o valor das reformas na prática, as quais foram implementadas e os resultados para pacientes/ clientes melhoraram; bem como a satisfação e capacidade profissional melhorada, e a criação de eficiências nos custos dos locais piloto também. [Hurley J, Dabars E, Bonner R. Experiência no programa: Melhores práticas de organizações líderes (BPSO) na Austrália. *MedUNAB* 2017; 20(2): 215-223]

Palavras-chave: Guia de Prática Clínica; Enfermagem; Prática Clínica Baseada em Evidências; Programas; Enfermagem Baseada em Evidências.

state and advocates strongly for effective health policies, workforce issues and negotiates industrial conditions (labour agreements) for its members (2). In addition, ANMF (SA Branch) is also a successful provider of vocational education and continuing professional development; also it has established its own legal practice to support members, and has recently founded the Rosemary Bryant AO Nursing & Midwifery Research Centre in collaboration with the University of South Australia (3).

ANMF (SA Branch) is proud to have been one of RNAO's first international partners to host the world-renowned BPSO Program in our country. This relationship has allowed us to grow the program locally within the vision and standards established by the RNAO.

So, after one full cycle-a three-year qualifying period-of the program locally, what has the experience in Australia been so far?

The RNAO BPSO program supports implementation of RNAO Best Practice Guidelines (BPG) at the organizational level (4). Established in 2003, it is internationally renowned and has been successful in demonstrating the uptake and utilization of BPGs. The program's strategic approach has served to promote the development and spread of evidence-based cultures, improve patient care, and to enrich the professional practice of nurses and other health-care providers. BPSOs commit to a qualifying period of three years, where a formal partnership is established and defines the role of RNAO and the expected deliverables of the BPSO. There are two models of the BPSO designation: BPSO Direct and BPSO Host. BPSOs Direct focus on enhancing their evidence-based nursing practice and decision-making cultures, with the mandate to implement and evaluate multiple clinical practice guidelines. In the case of ANMF (SA Branch), it entered a formal agreement with RNAO to become a BPSO Host, oversee the RNAO BPSO program in Australia, and to be responsible for all aspects of the program from selecting organizations interested in becoming BPSOs to reporting progress back to RNAO. At the end of the qualifying period, and assuming all deliverables are met, the BPSOs earn their designation and shift to focusing on sustainability and spreading of evidence-based practice.

The Birth of the Program in Australia

ANMF's dual role as a bargaining labour union and as the professional association means that we lead on a very wide range of activities, from professional standards, legislation and codes to political policies and wages and working conditions of our members. Many of these apparently separate roles do in fact overlap. For example, the regulation of safe staffing levels and skills mix in public hospital settings have been achieved by their inclusion in our bargaining agreements along with wages and working conditions, allowing enforcement through our legal system as necessary.

ANMF (SA Branch) seeks to advocate for, and partner with, our governments and health system managers to carry out reforms to health-care delivery and structures that will improve access to high quality and effective health services that optimize health outcomes for people and the community.

Unfortunately, when it suits the interests of bureaucrats, in particular, to attempt to narrowly describe our role they invariably use “the Union” terminology to draw attention away from our wider professional and political roles. In this case, it was suggested that the university sector could cover the area of evidence-based practice better.

Based in the academic sector as well as in South Australia, is the Joanna Briggs Institute (JBI), an international not-for-profit, research, and development Centre that support the

synthesis, transfer and use of evidence for the improvement of health-care outcomes. Given this proximity in site and goal, we worked with the JBI and showed the partnership potential and complementary components between our programs.

Explaining the program and its unique characteristics to local decision makers and funders was difficult. There was resistance to a program that would be hosted by “the Union.” In the end, the Health Minister made the decision that he would support the allocation of funds to the pilot project, in large measure, based on the additional investment of ANMF (SA Branch) funds.

Initial Barriers

We were funded, and advertised for, two pilot sites and received a number of inquiries; however, we struggled to get formal applications. The advertisement of the program was undertaken through the ANMF website, in publications and through direct correspondence to health services across the state. In addition, the Nursing & Midwifery Office of the Department of Health also circulated information to nurse executives via its own information system.

As a new program and in a healthcare environment that was overburdened by reforms and projects, creating interest in taking on yet another new pilot, was initially problematic.

The organizations that expressed interest before the program was funded withdrew interest due to other competing organizational and funding priorities at the time. We finally received a formal application from the Central Adelaide Rehabilitation Service (CARS), which was followed by an application from the whole Northern Adelaide Local Health Network (NALHN—a regional health authority). This allowed us to get the program underway with two very different organizations in terms of their size, scope, and focus.

Our first pilot site was small in number but huge in its achievements. Dr. Irmajean Bajnok, then RNAO Director of the International Affairs and Best Practice Guidelines Centre, facilitated the program supported by our BPSO lead.

This first BPSO Orientation Program was delivered very much as it was in Canada, and built on the relationships already established through international visits and exposure to training. This gave our pilot sites access to the wealth of knowledge and experience that the RNAO had built over the years in the development and implementation of the program.

Since that initial delivery, we have modified subsequent BPSO Orientations by increasing substantially the local support. The greater integration of the Host's leadership with

local implementation in Australia has meant that some of the work necessary to prepare the sites for implementation can be done during that process, rather than in advance.

We were greatly assisted by the monthly mentoring sessions with our RNAO BPSO Coach Dr. Bajnok and other RNAO team members, which we conducted by teleconference and/or webinars. This allowed modification of processes or approaches to the local context while remaining true to the principles and essential architecture of the program (5-7).

The Program Activation

We began the implementation at the Central Adelaide Rehabilitation Service (CARS), and it was a great site to work with in a pilot program. Being relatively small, with approximately 140 beds in two (2) locations and a small range of community based services, CARS had the additional benefit of also having a strong and singular focus on rehabilitation and recovery. It is home to the state-wide spinal and acquired brain injury rehabilitation services as well as a range of other generalist restorative care services.

Nurses in CARS loved this program! The site reported that the Best Practice Guidelines were constantly being borrowed from the project office and found in the wards.

We had very little difficulty in recruiting to the champion roles. As we have described earlier, in our implementation model we play a very direct role in the training and support of the champion's network within the candidate sites. This reduces the workload of the candidate site but increases the responsibilities and load we bear.

We began by planning for the sustainability of the program. CARS identified other quality systems and business

reporting obligations, and we explored how we could align our own evaluation systems with these. This has led to a capacity of our sites to align the evidence of the effect of their BPSO work with national accreditation standards, as well as meet their state health system quality reporting obligations (8) (Table 1).

The Program Maturing

The addition of Northern Adelaide Local Health Network (NALHN) to the BPSO cohort was a real test for the scalability of the program.

NALHN has two acute hospital sites totalling approximately 550 beds, and one of those sites is being transitioned to meet the tertiary care needs for the region's people. It is therefore experiencing growth, both in the number of patients and also the diversity and complexity of specialist services, with intensive care, cancer services, cardiology, specialist surgical and medical services. It also delivers a range of community and primary based services and a range of specialist mental health services (9).

We repeated and built on lessons learned from CARS. Nurses at CARS, particularly those in leadership and change champion roles, also acted to mentor staff from NALHN in relation to various aspects of the program (10).

In time, NALHN also worked to develop new ways of implementing and adapting things to meet their needs.

The rapid growth in services, change in the environment and staff cohorts meant that the organisation saw the need to invest in leadership development. Using the materials within the RNAO Implementation Toolkit, we ran leadership institutes across both CARS and NALHN, with great results.

Table 1. Give a title for this table

Standard 1: Governance for Safety and Quality in Health Service Organisations example mapped to the following RNAO, Best Practice Guidelines (8)

Clinical Best Practice Guidelines

Client Centred Care (9)

Care Transitions (10)

Healthy Work Environment Best Practice Guidelines

Collaborative Practice among Nursing Teams (11)

Developing and Sustaining Nursing Leadership (12)

Developing and Sustaining Effective Staffing and Workload Practices (13)

Source: Authors' own elaboration.

Evaluation of BPSO Impact at NALHN

To enable the comparison, and measure the impact of the NALHN BPSO Point of Care Leadership and Healthy Work Environment Institute, two surveys were administered pre- and post-workshop. Staff (n=30) participating in the workshops were presented with a series of knowledge, understanding and attitudinal statements, and asked to rate their level of agreement with those statements on a scale from 0 to 10. This was undertaken prior to the workshops. The repeat survey undertaken following attending the workshop has a response rate of n=29 so a high degree of comparability follows (10-13).

Describe the participants. How they were selected. Any sociodemographic data collected?

Permissions?. Institutional Review of this study?

Description of the instruments is needed. Validity and reliability?

How long was the data collected?. How much time between pre and post testing?

Then you present the results. (Chart 1, 2).

After the Leadership Institutes, knowledge, confidence and attitudes were all positively altered. In all cases the change was by an average in excess of 1 point (of the 10 point scale) with most showing change at or close to 2 points. What is the statistical significance of this change? You need to have this level of analyses before you present the results. This is required in all of the results presented.

Chart 1. Explores the responses relating to improved knowledge and understanding the relationship between leadership, work environments, professionalism, and client outcomes and organisational and system performance:

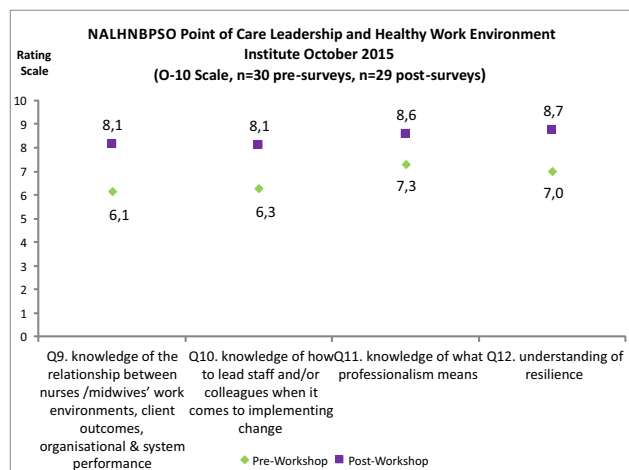


Chart 1. Knowledge Impact of NALHN BPSO Point of Care Leadership & Healthy Work Environment Institute.

- Knowledge of the relationship between nurses' work environments and client outcomes and organisational and system performance improved from a mean score of 6.1 out of 10 pre-workshop to 8.1 post-workshop.
- Knowledge of how to lead staff and/or colleagues when it comes to implementing change improved from a mean score of 6.3 out of 10 pre-workshop to 8.1 post-workshop.
- Knowledge of what professionalism means improved from a mean score of 7.3 out of 10 pre-workshop to 8.6 post-workshop.
- Understanding of resilience improved from a mean score of 7.0 out of 10 pre-workshop to 8.7 post-workshop.

Chart 2. Explores confidence in leading changes, promoting team work and resilience, to improve patient outcomes:

- Respondents' belief of having adequate knowledge about the relationship between fatigue and patient safety and risk, improved from a mean score of 6.7 out of 10 pre-workshop to 8.8 post-workshop.

Respondents' confidence in leading change in their work environment, improved from a mean score of 6.8 out of 10 pre-workshop to 8.3 post-workshop.

Respondents' confidence in their ability to create good team relationships, improved from a mean score of 7.1 out of 10 pre-workshop to 8.4 post-workshop.

Respondents' confidence in their ability to promote resilience, improved from a mean score of 6.6 out of 10 pre-workshop to 8.5 post-workshop.

Ensuring Sustainability – A focus on evidence of results

We were cognisant of the need to demonstrate outcomes from the pilot that would drive the Health Department to support its continuation. The evaluation showed encouraging results - both in the nurse and patient metrics.

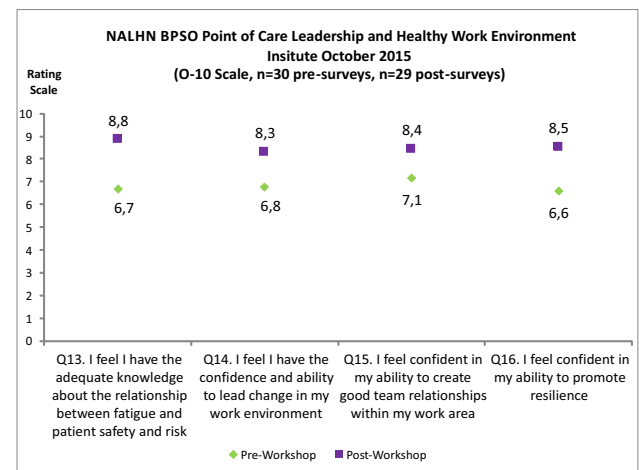


Chart 2. Confidence and Attitude Impact of NALHN BPSO Point of Care Leadership & Healthy Work Environment Institute.

Using CARS as our starting point, since they had the earlier start, we began to explore the clinical results which were impressive.

Patient/Client Experience

The following graphs show the measures (from the RAO NQuIRE Database) for patient/client experience across CARS showing improvement over the period after implementation. (Chart 3, 4, 5).

We were concerned by the apparent deterioration of results towards the end of the period. However, even that made sense when we considered the fact that there was a match between the lower scores and the organisational change resulting from service transfers (out of CARS) and announcements that the major site for rehabilitation was to close in the coming three years. Monitoring these results alerted nurse leaders to the impact on patient outcomes so that they could refocus their teams on patient care.

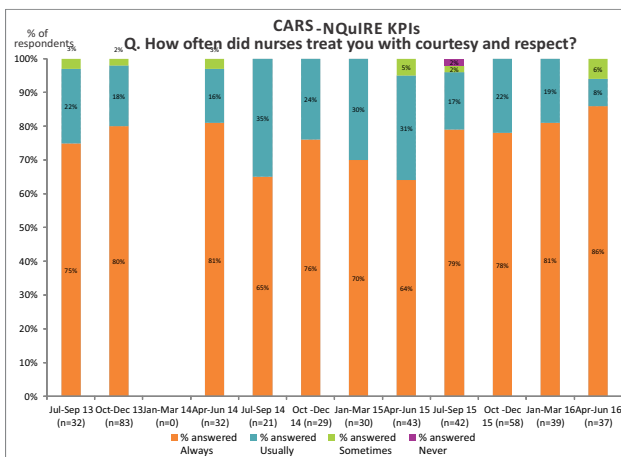


Chart 3. CARS – NQuIRE KPIs Q. How often did nurses treat you with courtesy and respect?

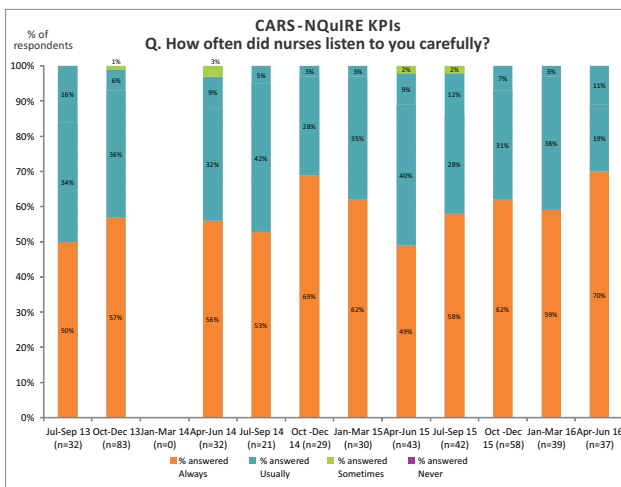


Chart 4. CARS – NQuIRE KPIs Q. How often did nurses listen to you carefully?

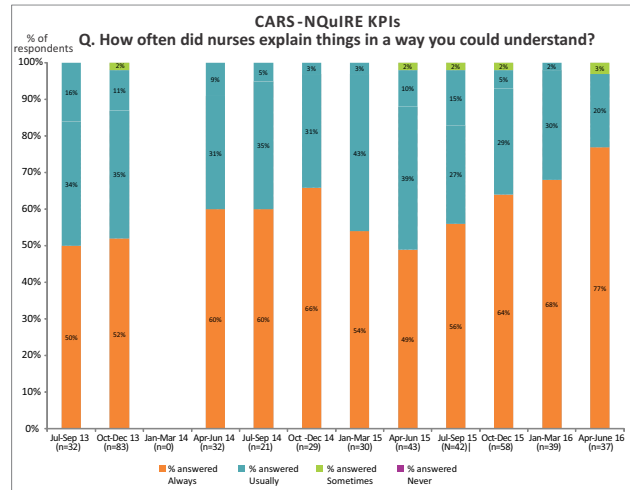


Chart 5. CARS – NQuIRE KPIs Q. How often did nurses explain things in a way you could understand?

Patient restraint had been a significant issue for the service. One of the selected BPGs related to the use of restraint, and the impact of its application to CARS was clear as the following charts demonstrate Chart 6, 7, 8.

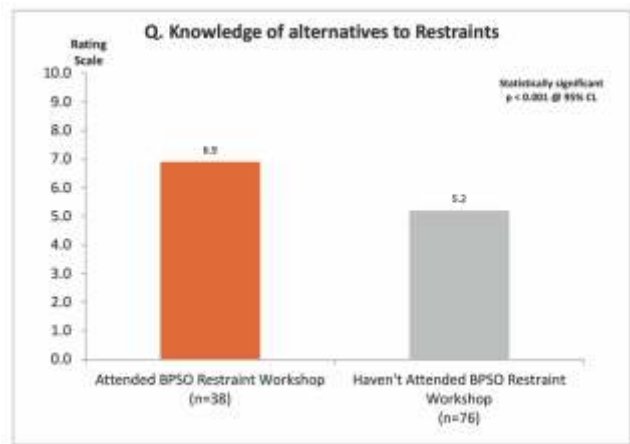


Chart 6. Q. Knowledge of Alternatives to Restraints.

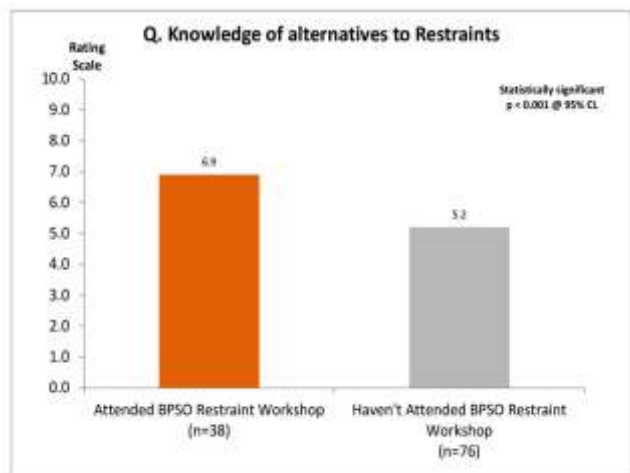


Chart 7. Q. Understanding of HOW to apply alternatives.

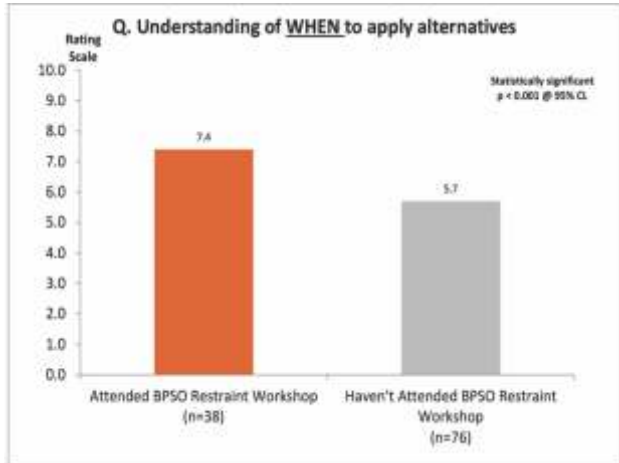


Chart 8. Q. Understanding of WHEN to apply alternatives.

Staff Survey Results Reflecting Changes in Knowledge and Understanding: Alternatives to Least Restraints

Nursing staff attending the workshops scored significantly higher in all three areas of knowledge and understanding than staff that did not attend.

The use of restraint (reportable under the safety and quality framework) was reduced after implementation by around 50% (14) (Chart 9).

There was a similar improvement in the number of patient falls reported over the period from a total of 11 incidents in 2012/13 to 5 in 2014/15 (14) (Chart 10).

This represents a reduction of 54.5% for CARS whilst the whole of SA Health showed an average reduction of 18.6% for the same period providing support for claims that local change factors drove the change rather than whole of health system changes.

Another measure known to be sensitive to changes in the quality of nursing care is hospital acquired pressure ulcers (HAPUs). CARS once again showed very significant improvement with rates halving from 78 in 2012/13 to 39 in 2014/15 (14) (Chart 11).

Demonstrating Economic Return

The Australian health system, like most around the world, is increasingly focused on “the bottom line.” For this reason, and because the value proposition is of genuine importance, we gave thought as to how we could begin to demonstrate the economic argument for evidence-based practice alongside the nursing and clinical impacts (15, 16).

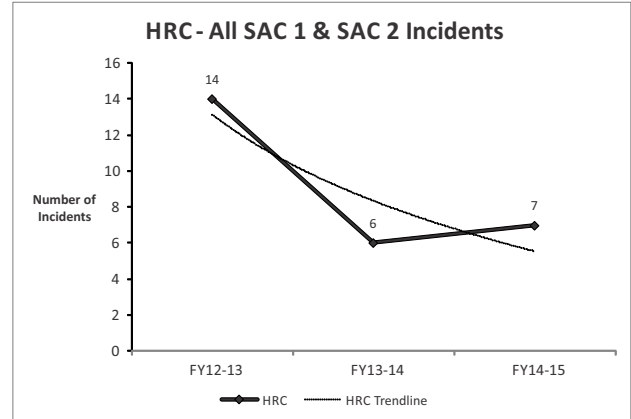


Chart 9. HRC – All SAC 1 & SAC 2 Incidents

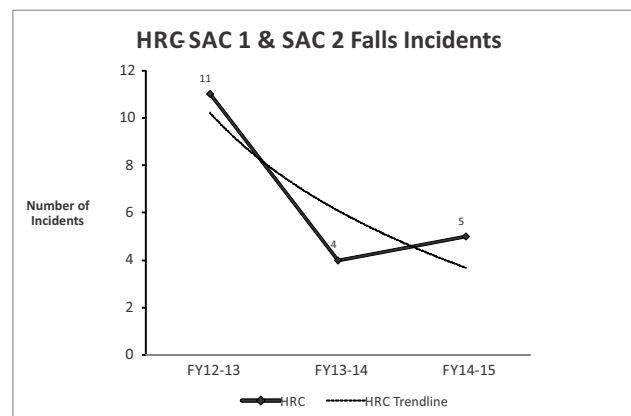


Chart 10. HRC – Falls SAC 1 & SAC 2 Incidents.

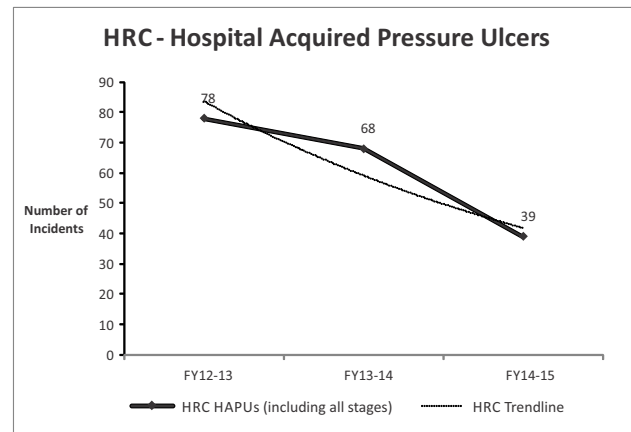


Chart 11. HRC – Hospital Acquired Pressure Ulcers.

Converting the learnings to an economic impact is less developed and understood, although in some cases, is obvious. Measures that reduce the length of stay in hospital through interventions, such as those that reduced the incidence of pressure ulcers, urinary tract infections, and falls, are well reported (17-20). The fact that there is a reduction in the length of stay clearly impacts on cost of care but is rarely quantified in the reports.

RNAO estimated that in terms of financial outcomes, reduced prevalence of pressure ulcer results in saving of minimum \$9,000 pressure ulcer. RNAO also states that reduced injury from falls results in savings of minimum \$35,000/fall. This must be documented, rather than estimated.

Using the RNAO benchmarks and literature review of economic analysis, we valued the savings to be \$210,000 from changed performance in those areas and the resulting reduction in number of falls. A further \$351,000 could be attributed to reduced HAPU (14).

Given that the grants to worksites participating in the program were a total of \$100,000 per year, the return on investment from these (recurrent) savings alone more than made the case for the program.

Increasingly we need to be capable of building reports that show the value of nursing practice, nursing decision making and leadership of the care program.

Conclusion

RNAO's well-established processes and systems were very conducive to initiating the BPSO Program in Australia. Modification of those processes to meet the particular role and circumstances of the Australian Host, through negotiation with RNAO, permitted a more efficient use of resources locally whilst retaining a model consistent with the rigour of the program.

Demonstration of improved clinical care and professional practice was evident in the evaluation of the pilot sites. However further funding commitment necessary for the extension of the program to other sites was not provided until we could also establish improved economic performance in addition.

The integration of evaluation measures with other performance and reporting systems in the candidate sites improved reporting, and also gave richer data that supported processes for accreditation and performance reports for the organisations.

Whether providing evidence for funding of this program, arguing to sustain nursing positions or to support improved wages or working conditions, we need to be able to demonstrate impact across all of the relevant domains. In an increasingly cost constrained health-care system, one of these domains is, and will, focus on economic or financial criteria.

If as nursing organisations we do not work to frame evidence that will meet the needs of decision makers, we will weaken our capacity to influence outcomes that would benefit not only nursing and midwifery staff but the patients and clients that receive their care.

Conflict of Interests

The authors state that they have no conflict of interest.

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