The Role of Nursing Educators and Healthcare Leaders in Teaching and Sustaining Evidence-based Practice

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The State of Healthcare

• There are up to 200,000 unintended patient deaths per year (more than auto accidents & breast cancer)

• Patients only receive about 55% of the care that they should when entering the healthcare system

• Poor quality healthcare costs the United States about 720 billion dollars every year

• It often takes decades to translate research findings into clinical practice to improve care and outcomes

• The U.S. healthcare system could reduce its healthcare spending by 30% if patients receive evidence-based healthcare
Patient Outcomes With and Without Evidence-Based Practice

- Traditional Practice
- Evidence-Based Practice

Bar chart showing a comparison between traditional practice and evidence-based practice.
The State of Nursing Education

- Many schools continue to teach bachelor’s and master’s students the rigorous process of how to conduct research versus how to take an evidence-based approach to care.

- Many schools are preparing DNP students as researchers instead of the best translators of evidence from research into practice to improve healthcare quality and patient outcomes.

- The DNP focuses on leadership for EBP (AACN, 2012).

- Faculty can not teach what they themselves do not know; given the average age of nursing faculty, many grew up with research, not evidence-based practice.
Focus of the DNP versus PhD

**DNP**
- EBP and the translation of external evidence into clinical practice and policy to improve care and patient outcomes
- Generation of internal evidence through quality improvement/outcomes management/EBP projects
- Mentorship of others in EBP and the creation of systems to sustain it

**PhD**
- Generation of rigorous research/external evidence, including translational research, to inform practice and policy
- Extension of science
- Generation of evidence-based theories

**Improved Patient/Population/Policy Outcomes**
The Merging of Science and Art: EBP within a Context of Caring & EBP Culture and Environment Results in the Highest Quality of Patient Care

Context of Caring

- Research Evidence & Evidence-based Theories
- Clinical Expertise and Evidence from assessment of the patient’s history and condition as well as healthcare resources
- Patient Preferences and Values

Clinical Decision-making

EBP Culture & Environment

Quality Patient Outcomes

© Melnyk & Fineout-Overholt, 2003
The So *What Outcome* Factor in an Era of Healthcare Reform

- Conducting research and EBP projects with high impact potential to positively change healthcare systems, reduce costs and improve outcomes for patients and their families.

- Key questions when embarking on a research study or an EBP project:

  * **So what** will be the end outcome of the study or EBP project once it is completed?

  * **So what** difference will the study or EBP project make in improving healthcare quality, costs or patient outcomes?

- Nursing studies and EBP projects must include *so what outcomes* that currently matter to the healthcare system.
Reducing NICU Length of Stay, Hospital Costs and Readmission Rates with the COPE (Creating Opportunities for Parent Empowerment) for Parents of Preterms

FUNDING FOR THIS WORK BY THE NATIONAL INSTITUTE OF NURSING RESEARCH
R01#05077
NR05077-04S1
The COPE NICU Program
A 4 Day Shorter Length of Stay (LOS) for COPE Preterms Resulted in Cost Savings of $5000 per infant; 8 Day Shorter LOS for Preterms < 32 Weeks

*\( p < .05 \)
The Steps of EBP

- Step 0: Cultivate a Spirit of Inquiry & EBP Culture
- 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 Your 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)
Levels of Evidence

1. Evidence obtained from well-designed controlled trials without randomization and from well-designed case-control and cohort studies.
2. Evidence from systematic reviews of descriptive and qualitative studies.
3. Evidence from a single descriptive or qualitative study.
4. Evidence from the opinion of authorities and/or reports of expert committees.
5. Usefulness for Cause & Effect Decision Making.

Systematic review or meta-analysis of all relevant randomized controlled trials (RCTs), evidence-based clinical practice guidelines based on systematic reviews of RCTs.
Findings from our EBP Survey with U.S. Nurses

(Melnyk et al., JONA, 2012)

- 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.
<table>
<thead>
<tr>
<th>Statement</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>EBP is consistently implemented in my healthcare system</td>
<td>53.6</td>
</tr>
<tr>
<td>My colleagues consistently implement EBP with their patients</td>
<td>34.5</td>
</tr>
<tr>
<td>Findings from research studies are consistently implemented in my institution to improve patient outcomes</td>
<td>46.4</td>
</tr>
<tr>
<td>EBP mentors are available in my healthcare system to help me with EBP</td>
<td>32.5</td>
</tr>
<tr>
<td>It is important for me to receive more education and skills building in EBP</td>
<td>76.2</td>
</tr>
</tbody>
</table>
The One Thing That Prevents You From Implementing EBP

<table>
<thead>
<tr>
<th></th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time</td>
<td>151</td>
</tr>
<tr>
<td>2. Organizational culture, including policies and procedures,</td>
<td>123</td>
</tr>
<tr>
<td>politics, and a philosophy of “that is the way we have always</td>
<td></td>
</tr>
<tr>
<td>done it here.”</td>
<td></td>
</tr>
<tr>
<td>3. Lack of EBP knowledge/education</td>
<td>61</td>
</tr>
<tr>
<td>4. Lack of access to evidence/information</td>
<td>55</td>
</tr>
<tr>
<td>5. <strong>Manager/leader resistance</strong></td>
<td>51</td>
</tr>
<tr>
<td>6. Workload/staffing, including patient ratios</td>
<td>48</td>
</tr>
<tr>
<td>7. Nursing (staff) resistance</td>
<td>46</td>
</tr>
<tr>
<td>8. Physician resistance</td>
<td>34</td>
</tr>
<tr>
<td>9. Budget/payors</td>
<td>24</td>
</tr>
<tr>
<td>10. Lack of resources</td>
<td>20</td>
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A Recent National Survey of 276 Chief Nurse Executives Across the U.S

- 93% currently in the CNO role
- Ages ranged from 32-68 (M= 55 years)
- Years in practice ranged from 8-47 (M=31 years)
- Years as a CNO ranged from <1- 32 (M= 9 years)
- 92% female; 94% White
- 6% bachelor’s degree; 69% master’s degree;
- 8% PhD prepared; 10% DNP prepared
- 45 States and DC represented
- 18% work in Magnet facilities
- 55% reported having clinical ladder systems
- 47% had no ongoing nursing research projects

Funded by Elsevier
## What % of your annual operating budget do you spend on building and sustaining EBP in your organization?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>0</td>
<td>15%</td>
</tr>
<tr>
<td>1 to 10</td>
<td>59%</td>
</tr>
<tr>
<td>11 to 25</td>
<td>18%</td>
</tr>
<tr>
<td>26 to 50</td>
<td>5%</td>
</tr>
<tr>
<td>51 to 100</td>
<td>2%</td>
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</tbody>
</table>
Performance Metrics

NDNQI Metrics

- Falls
- Falls with Injury
- Pressure Ulcers
- Pressure Ulcers (Stage 2 and above)
- Restraints
- Nursing Hours
- Care RN Education
- RN Certification

Legend:
- Below benchmark
- At benchmark
- Exceeding benchmark
Performance Metrics
Core Measures

- Catheter-associated Urinary Tract Infections
- Pressure Ulcers (Stage 3 and 4)
- Vascular Catheter-associated Infections
- Falls and Trauma
- Manifestations of Poor Glycemic Control

Below National Rate
Same as National Rate
Above National Rate
Top Priorities

As a CNO/CNE, what are the top priorities that you are currently focused on in your role?

- Quality: 25%
- Patient Safety: 14%
- Benchmarks: 10%
- Finance: 9%
- Recruitment and Retention: 6%
- Staffing: 5%
- Patient Satisfaction: 4%
- Vision/Culture: 3%
- Evidence-based Practice: 2%
A Call to Action for Healthcare Leaders to Build Sustainable Cultures and Environments for EBP

- **A philosophy, mission and commitment to EBP:** there must be organizational commitment to advance EBP as evidenced by tactics such as orientations and workshops that teach EBP skills and clinical ladders that incorporate EBP competencies.

- **A Spirit of Inquiry:** all health professionals are encouraged to question their current practices.

- **A Cadre of EBP Mentors:** who have in depth knowledge and skills in EBP, mentoring others, and overcoming barriers to individual and organizational change.
Critical Components of an EBP Culture

- **Administrative Role Modeling and Support**: leaders and managers 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, such as computers for searching and up to date data bases.

- **Recognition**: individuals and interprofessional teams are rewarded regularly for EBP.
New EBP Competencies for Practicing & Advanced Practice Nurses in Healthcare Settings

- Creation of EBP competencies by 7 national experts

- Confirmed with two rounds of a Delphi Survey with EBP mentors across the U.S.

- Newly published in *Worldviews on Evidence-based Nursing* (February of 2014; Melnyk, Gallagher-Ford, Long & Fineout-Overholt)
A Call to Action for Nursing Educators

- Faculty must have expert EBP knowledge and skills in order to teach EBP.
- EBP must be the foundation of care, and be integrated throughout entire academic programs in both didactic and clinical courses.
- There must be clarity in the preparation of students in EBP at the bachelor’s, master’s and doctoral levels.
- Faculty in PhD programs need to prepare more intervention researchers.
- Faculty and healthcare leaders must work together to ensure consistency between what is being taught in academic programs and implemented in real world clinical settings.
“...because we’ve always done it that way.”

Anonymous
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