Promoting a Culture of Evidence-Based Practice Through a Change Request Process

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Evidence-based practice (EBP) is a problem-solving approach to health care clinical decision making that integrates the best evidence from well-designed studies with clinician expertise and a patient's preferences and values.[1] Although EBP has been associated with a higher quality of care and improved patient outcomes, organizations continue to face challenges and barriers in implementing and sustaining a culture of EBP.[2] These barriers include lack of knowledge and skills by health care providers, resistance to EBP, time, misunderstanding of EBP, and lack of financial commitment.[1] This article describes how a 715-bed, 2-hospital health care system in Southwest Florida implemented a formal process to support clinical and organizational autonomy and foster a culture of evidence-based practice.

EXISTING INFRASTRUCTURES

The examination of how to best enculturate EBP initiated with an evaluation of the current infrastructures that could be used to support the culture shift. Our organization made great strides in improving patient safety outcomes, and our experiences with changing culture taught us that in order to be successful with building a culture of EBP, we needed to integrate the concepts into existing structures, being careful not to introduce it as "additional work," but as a way of being.

An analysis of strengths and opportunities revealed that there were greater strengths than originally perceived with existing infrastructures that would be ideal to leverage in building a culture of EBP. These included having support from the executive leadership team; a newly created director of research and evidence-based practice role; an organizational commitment to pursuing Pathway to Excellence® re-designation and Magnet® initial designation; a clinical ladder program that promotes academic progression, professional certification attainment, and participation in quality improvement projects; and a nurse residency program that allows us to target novice nurses in the journey.

Two major strengths that eventually served as the catalysts for building an EBP culture were the nursing professional practice model (PPM) and shared governance model, known as the shared decision-making model. A PPM serves as a framework that reflects nursing values and beliefs (culture) about the delivery of patient care.[3] PPMs and EBP go hand-in-hand because PPMs provide a foundation for safe, high-quality patient-centered care and empower nurses to lead care. The PPM at our organization comprises concepts that are interwoven with EBP principles. These include innovation, shared decision making, quality and safety, professional development, teamwork, and collaboration.

The opportunity identified in relation to the PPM was the need to articulate and teach nurses how EBP was integrated in each component of the PPM and in their daily work. For example, nurses articulated they believed in the need to pursue continuing education and embrace life-long learning to provide better patient care. This belief reflects the professional development component of the PPM. When discussing this belief, nurses are educated about the importance of staying current with research and their role in utilizing research in the clinical setting to enhance. not only their own professional development, but also patient outcomes.

The shared decision-making model serves as the vehicle for clinical and organizational autonomy and ultimately serves as the platform for practice discussions, idea generation, knowledge sharing, teaching, and learning. Shared decision making is also reflected in the PPM.

SHARED DECISION MAKING

The best way to support nurses in continuously questioning the "status quo" is to ensure they can exercise clinical and organizational autonomy and have a level of comfort in questioning current practices. Clinical autonomy refers to the authority and freedom of nurses to make nursing care decisions concerning the content of clinical patient care within interprofessional practice evironments.[4] Organizational autonomy refers to the authority and freedom of a nurse to be involved in broader unit, service line, organization, or system decision-making processes pertaining to patient care, policies and procedures, and work environment.[4] The internal system that empowers nurses with the opportunity to influence patient care and the practice environment is the shared decision-making structure.

The purpose of the shared decision-making model is to create an innovative process that empowers nurses and other staff members at all levels to contribute collaboratively to nursing practice, standards, and quality of care. It is founded on the principles of equity, teamwork, accountability, and autonomy. Nurses at all levels of our organization have a professional obligation to participate in developing the future of nursing. The collaborative model incorporates a 3-tiered structure that includes a system level, service line, and unit level to engage all members of the nursing department.

Each level represents nursing in a different way. The system level councils represent the relationship within the nursing department and all that it serves. The responsibilities of these councils are to help guide the practice and policy decisions that impact the entire continuum of care or more than three service lines. The service line councils are focused on the individual service lines and all that they serve, including specific service line policy decisions. The unit level leads addresses unit-level concerns while implementing and supporting system and service line decisions and initiatives. This is where information is distributed and shared from the councils.

CHANGE REQUESTS

A major component of our shared decision-making model that supports a spirit of clinical inquiry and fosters an evidence-based practice culture is the *change request* process. The change request process is a formal process that encourages employees to make recommendations or suggestions to either initiate a practice change, or ask questions about why a practice exists. The process requires that nurses complete an application, supplemented with supporting evidence, related to the desired change (*Figure 1*). The change request can be initiated by nurses or other employees who directly or indirectly collaborate with nursing and influence nursing practice environments.

The notion of implementing a formal application process for change requests served 3 purposes. First, it would allow the nursing department the ability to track outcomes associated with change requests made by nurses. Second, it would encourage nurses to begin evaluating and appraising the literature; and third, it would provide for a formal process for moving suggestions forward. Oftentimes, nurses had communicated that they did not have a formal mechanism for moving suggestions forward.

Before the introduction of the change request process, nurses would communicate suggestions for practice changes, but the ideas remained stagnant without a structure or process to guide the practice change. Nurses shared not knowing how to introduce the literature or content learned through conferences or their profession organizations into the practice setting. The practice change application process serves as the mechanism to implementing research findings.

In addition to the application process, a *spirit of inquiry* algorithm was developed so that nurses could understand and anticipate the funneling of the change request (*Figure 2*). The algorithm was added to the model to further strengthen the change request process and to provide a framework for the decision-making process along the shared decision-making continuum. The spirit of inquiry algorithm provides clinicians guidance for how to move ideas and suggestions to appropriate councils for actualization. It begins with a basic starting point, "Employee has an idea/suggestion for a practice change." There are 2 branches in which an employee can move this idea forward: through a suggestion box found on the nursing intranet site or through an electronic or paper formal application also found on the nursing intranet site. Both branches require supporting evidence and result in appropriation into the relevant shared decision-making council that will work on implementing and actualizing the change.