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Editorial

*Corresponding author
Lindsey Bird, MSN, RN, CNL, CCRN
Registered Nurse
CVICU, Le Bonheur Children's Hospital
848 Adams Ave.
Memphis, TN 38013, USA
Tel. 901-292-3869
E-mail: Lindsey.Bird@lebonheur.org

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Evidence-Based Practice: Are we getting there?

Lindsey Bird, MSN, RN, CNL, CCRN*

Registered Nurse, CVICU, Le Bonheur Children's Hospital, 848 Adams Ave., Memphis, TN 38013, USA

The need for Evidence-Based Practice (EBP) at the point of care has been well emphasized and identified by the Institute of Medicine (IOM) as a core competency for bedside clinicians.[1] More than research utilization, EBP is a clinical problem-solving process that begins with a spirit of inquiry. It continues with appropriately formatting a clinical question, allowing a productive literature search. Once the evidence is critically appraised, it is integrated into clinical experience and relevancy to a patient population. Finally, the clinician evaluates the outcome and, when appropriate, disseminates the findings.[2] EBP empowers nurses to act as agents of change by giving them the tools to offer the highest-quality patient outcomes. Nursing baccalaureate and residency programs have made substantial progress in addressing the IOM's call for EBP-competent clinicians by integrating EBP into their curriculums. Novice nurses, however, are adjusting to a new practice setting and lack context for the final steps of the EBP process. The expert in this area is the experienced nurse, but thus far they have not been targeted as rigorously as graduate nurses in use and relevancy of EBP. Recent surveys highlight this deficit, indicating that bedside nurses are still not consistently utilizing EBP.[3]

If practicing nurses are not routinely utilizing evidence to inform their care, then novice nurses are not received into a system that supports the skills gained in their education. This discontinuity between academia and clinical practice threatens to weaken the momentum gained in educating the newest generation of nurses. An integral component in sustaining the paradigm shift called for by the IOM is the cohort of experienced nurses, and it is here where there is work to be done.

The host of new practices in a new practice setting can overwhelm a novice nurse and may temper their enthusiasm for EBP. To carry their skill set to the point of care, novice nurses need reinforcement and guidance in reconciling theory and implementation of EBP. Practicing nurses the key facilitators, but they need both belief in the value of EBP and the skills to engage in the process. If these factors remain unaddressed, there is risk for losing the investment made in EBP-competent graduate nurses. Take, for example, the common practice of inline suctioning an endotracheal tube. A new nurse may question when it is appropriate to lavage the airway with normal saline, and an experienced nurse who lacks proficiency in EBP is more likely to defer to anecdotal experience or collective opinion for the answer. The two parties in this conversation are hindered by lack of a shared mental model; both bring valuable insight, but a nurse without an EBP skill set cannot effectively mentor the novice nurse in exploring a clinical inquiry. Conversely, when the experienced nurse is also proficient in EBP, the dynamics of the interaction change.

The decision about use of saline with inline suctioning will be supported by both evidence and clinical expertise, illustrating the applicability of EBP at the point of care and developing the capacity built in nursing education. There are innumerable opportunities for dialogue about care guided by evidence within any practice setting, but they cannot be capitalized upon without a common language. The necessity of a cadre of EBP-competent nurses understood, the question that remains is how to best reach them?

Garnering support for EBP can be a challenge, as it has propensity to feel like another obligation to a population whose practice has already adapted to a host of changes. Additionally,

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its message is often cloaked in the idea that it contrasts the judgment crafted throughout a career. Furthermore, a lack of confidence in the ability to find the evidence-based answer to a clinical question is a significant barrier to EBP use.[4,5] One key strategy for addressing both misconceptions and feasibility is to train and establish EBP mentors.[6] When clinicians at the point of care are proficient in EBP, they reinforce the message that EBP compliments nursing experience. Ideal candidates to act as mentors are clinical preceptors, as they have already identified themselves as having the desire and aptitude to mentor novice nurses. Clinical educators are also well suited to the role of EBP mentors, as they are resources for best practice and continuing education. Many institutions have structured training in place for these roles, into which additional EBP training could be incorporated. Preceptors and educators work alongside experienced colleagues daily and are also key contacts for new nurses. Their unique position brings significant opportunity for facilitating the movement of EBP from academia to the bedside. Other opportunities for bringing experienced nurses into an EBP culture exist in EBP-focused nursing grand rounds and the development of clinical practice councils to serve as resources. Each of these strategies requires investment on the organization's part, but they optimize use of resources by building upon infrastructure already in place in many institutions.

Building and sustaining an EBP culture is imperative in ensuring high-quality patient outcomes. The efforts in educating graduate nurses in use of EBP are necessary to establish a new baseline in care, but they are a poor investment if not well bridged to experienced nurses. Providing experienced nurses the insight and skills to be proficient in EBP is the most reliable way to assure that the transition from graduate to bedside nurse supports the adaptation of EBP to health care systems. To achieve an effective paradigm shift with EBP as a functional component of care delivery, organizations must diligently pursue their current bedside clinicians to act as EBP champions.

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