Feature Article

Clinical Nurse Specialists Shaping Policies and Procedures Via an Evidence-Based Clinical Practice Council

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In the practice of nursing, organizations with progressive evidence-based practice programs implement structures and processes whereby nurses are engaged in the review of existing research and in the development of clinical practice documents to better align nursing practices with the best available scientific knowledge. At our academic hospital system, clinical nurse specialists (CNSs) took the lead to help transform a traditional nursing policy and procedure committee into a hospital-wide, staff-represented Clinical Practice Council (CPC) that ensures evidence-based nursing practices are reflected in the organization's nursing practice documents for the provision of patient care. Clinical nurse specialists function as mentors and cochairs who are dedicated to ensuring that nursing practice is supported by the latest evidence and committed to guiding staff nurses to continually move their practice forward. The success of the CPC is due to the leadership and commitment of the CNSs. This article describes the structure, process, and outcomes of an effective CPC where CNSs successfully engage frontline clinicians in promoting nursing care that is evidence based. Clinical nurse specialist leadership is increasingly made visible as CNSs effectively involve staff nurses in practice reforms to improve patient outcomes.

KEY WORDS:
clinical nurse specialist, clinical practice council

Progressive organizations with commitment to a culture of evidence-based practice (EBP) must implement structures and processes whereby nurses engage in the review of existing research to better align nursing practices with the best available scientific knowledge.[1–8] To enhance staff nurses' influence over nursing practice, our academic hospital system took the lead to transform our traditional nursing policy and procedure committee into a hospital-wide, staff nurse–represented Clinical Practice Council (CPC). The CPC ensures that EBPs are reflected in the organization's nursing practice documents for the nurses' provision of patient care. Clinical nurse specialists (CNSs) provide leadership by serving as council cochairs and mentoring staff nurses in the integrated effort to evaluate evidence and revise nursing practice documents.

This article describes the structure, process, and outcomes of an effective CPC where CNSs successfully engage frontline clinicians in promoting nursing care that is evidence based. Clinical nurse specialist leadership and effectiveness are increasingly made visible as CNSs involve staff nurses in practice reforms that provide evidence-based care that is safe and effective to improve patients' outcomes.

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PURPOSE OF THE COUNCIL

Historically, hospital nursing policy and procedure committees have focused mainly on the process of policy review, with limited reliance on research and evidence-based literature to guide changes in practice documents and with minimal involvement of staff nurses.[9,10] In an effort to address the variability in clinical practice and to integrate research within our department of nursing, the CPC was established to accomplish the following goals:

- Foster exemplary patient care through the development, review, and dissemination of clinical nursing policies, procedures, and institutional guidelines of care.
- Ensure that practice documents are aligned with the latest research and evidence.
- Provide a forum that stimulates innovative thinking among frontline clinicians regarding integrating evidence into current practices.
- Provide a mechanism for dissemination and feedback regarding new practices among frontline clinicians.

The CPC facilitates recognition of the staff nurses' clinical expertise and influence to guide clinical practice. Moreover, through their involvement with the CPC, staff nurses encourage a culture of inquiry that facilitates innovation. Members of the CPC give thoughtful consideration to practices that are efficient and effective in improving patients' outcomes. The CPC encourages accountability, ownership, and the promotion of clinical policies, procedures, institutional guidelines of care, and competencies throughout the hospital system.

STRUCTURE OF THE COUNCIL

Staff nurses with strong clinical knowledge and leadership skills from each unit in the hospital represent the unique needs of their specific unit and help ensure consistent nursing practices in their unit and throughout the hospital. The monthly 4-hour council meetings provide opportunities for advanced learning regarding research and EBP, and the meetings entail actual group and council work in the following areas: (1) retrieval, critique, and synthesis of evidence-based literature; (2) interpretation and evaluation of current evidence; (3) review and revision of policies and other practice documents; (4) performance as a member of a nursing team within council structures; (5) dissemination of EBP changes; and (6) clinical role modeling and leadership skills.

Because of the existence of many specialty areas, the CPC has 3 major subgroups (ie, critical care—emergency; intermediate care—medical surgical; and pediatrics, neonate, and perinatal). Each subgroup, which varies in size from 10 to 15 nurses, is cochaired by 1 or 2 CNSs who are knowledgeable in EBP and able to mentor staff in developing EBP documents. A doctorally prepared director of research and EBP serves as the chair of the CPC and as a mentor for research and EBP. Since initiation of the CPC several years ago, additional EBP mentors have been assigned to each of the 3 subgroups. Figure 1 graphically displays the organizational structure of the CPC.

SELECTION OF STAFF NURSE REPRESENTATIVES

Each CPC unit representative is selected by the unit leaders (unit director [manager], CNS, or educator) in accordance with specified criteria. To create a council that is highly effective and successful in achieving its goal, the following selection criteria are used when appointing unit representatives:

- minimum of 2 years of nursing experience
- minimum of 1-year tenure in the current clinical area
- ideally employed full-time or at least 50% time
- expressed interest in growing in clinical leadership by influencing the unit's clinical nursing practice
- expressed interest in learning about the goals and activities of the council related to development of practice documents
- able to commit to being unit representative for at least 2 years
- interest in partnering with other unit representatives to discuss practices in light of latest evidence
- is considered an informal leader among peers

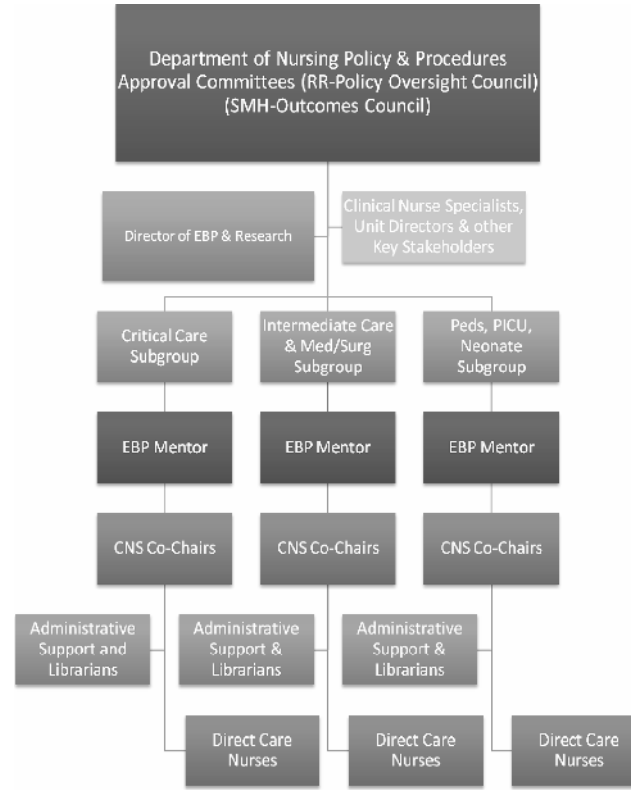

FIGURE 1. Clinical practice council organizational chart.

- meets or exceeds expected clinical performance based on the job description/performance evaluation
- commits to sharing and disseminating new practice recommendations with unit colleagues.

Each CPC representative signs an agreement that delineates the expected adherence to council protocol. This protocol includes regular meeting attendance (a maximum of 2 missed meetings annually), active participation in all phases of document development, and dissemination and reinforcement of practice changes and the supporting evidence to their respective unit nurse colleagues. The agreement is cosigned by the unit leadership and submitted to the director of research and EBP.

ROLE AND PREPARATION OF STAFF NURSE REPRESENTATIVES

To ensure success of CPC representatives, an initial formal orientation and ongoing educational sessions are provided at each monthly meeting. The formal orientation consists of 2 parts. The first part is a verbal discussion by the CNS cochair about the purpose, structure, processes, and expectations of the CPC members of their subgroup. The second part of the orientation involves the review and completion of a self-study module consisting of an overview about EBP and the relationship to the purpose and goals of the CPC. A posttest of this self-study module is completed by all new CPC representatives.

Recurring education programs are also provided for CPC nurse representatives. These monthly didactic sessions cover a range of EBP topics and are given during the first 30 to 45 minutes of each meeting. Topics include the following: what is EBP, determining the levels of evidence, searching and retrieving the evidence, critiquing and synthesizing the evidence, and determining if the evidence supports a practice change. In addition, operationalizing the CPC's role as a clinical leader and disseminator of practice changes is discussed. Immediately after the educational session, the entire council has an opportunity for discussion, questions, and feedback.

The interactive educational offerings are provided by doctorally prepared EBP mentors to facilitate nurses' use of EBP. The education provides the foundation for the CPC representatives to successfully evaluate scientific literature and harvest the most valuable findings for nursing practice. The knowledge gained by CPC nurses empowers them with the complex skills needed to navigate reading nursing research studies and decipher the strength and levels of research and other levels of evidence to identify relevant findings.

The EBP education series is supplemented by informal yet vital mentoring of CPC representatives during the council meeting by both the CNS cochairs and EBP mentors. Knowledge of and familiarity with EBP expand the clinicians' confidence to contribute suggestions during council meetings and to disseminate the practice documents to their unit colleagues.

SELECTION OF CNS COCHAIRS

By virtue of their advanced education, familiarity with graduate-level research, and experience within a clinical specialty, the CNS acting as a cochair is integral to the functioning of the CPC. A CNS with practical experience in developing and implementing nursing practice documents, competencies, and leading change is invaluable to the CPC nurse representatives.[11,12]

The CNS cochairs are selected on the basis of their performance in their clinical area and their commitment to ensuring that clinical practice is evidence based. Selection criteria for CNS cochairs include (1) a minimum of 1 year of CNS experience, (2) commitment to the need for EBP throughout the nursing department and across the healthcare system, (3) ability to conduct a meeting and facilitate a group effectively, (4) ability to be well organized, and (5) willingness to provide a sustained commitment and passion for the council.

The CNS cochairs are appointed by their supervisors, who are nurse executives from 2 of the hospitals within the healthcare system.

ORGANIZATIONAL SUPPORT

Because of the unit manager's accountability for resources, administrative support of the staff nurse CPC representative begins with the finances and staffing coverage.[13] The dedicated and protected time away from the bedside is considered "nonproductive" hours and a challenge to meet in the current healthcare environment. Each nurse is allocated 4 hours per month to attend the meetings, and these hours cannot be designated as "overtime." At the UCLA Health System, a separate cost center funds these hours. The CPC unit representative is a skilled experienced nurse, and thus the involvement of the unit managers is of utmost importance to ensure that adequate staffing coverage is available.

As most CPC representatives have a baccalaureate degree or associate degree, exposure to and experience with the intricacies of researching professional academic databases for relevant literature are often minimal.[12,14–16] A biomedical librarian provides support for teaching CPC representatives the skills of searching for and retrieving evidence and can perform up-to-date searches on requests of the CNS cochairs.

In addition, the Nursing Research and Education Department provides dedicated rooms of sufficient size for the large group meeting and smaller areas for the subgroup meetings. Each of the rooms has a minimum of 1 computer with online access, an attached printer, and

a projector with technical support for this equipment provided by personnel in the Nursing Research and Education Department.

Master's degree–prepared CNSs serve as cochairs of the CPC, with mentorship from doctorally prepared clinicians.

The doctorally prepared clinicians serve as EBP mentors. They provide mentoring to the CNS cochairs and the CPC unit representatives at both CNS cochair meetings and monthly CPC meetings. The mentors provide support in areas of research methods, understanding research reports, and assisting with the integration of research findings into practice documents. Their advanced knowledge of research and EBP is particularly useful when appraising and synthesizing evidence. The expertise of the EBP mentors provides a valuable resource for CNS cochairs and CPC representatives and adds to developing practice documents that are based on current science versus anecdotal experience.

ROLE AND PREPARATION OF THE CNS COCHAIR

The role of the CNS cochair is to facilitate the subgroup activities, integrating representatives from different units and across the system to work as a team. The CNS cochairs ensure that all members have input and an equal voice and maintain group focus and direction. Subgroup activities include brainstorming and prioritizing clinical practice issues that are appropriate for CPC review; searching, reviewing, and synthesizing the latest evidence; and revising/developing the practice document (policy, procedure, or institutional guideline of care) and the associated clinical practice alerts, posttests, and competencies.

The CNS orients new members to the subgroup and further provides coaching and mentoring of staff nurses in the skills necessary for literature review and synthesis, development of practice documents, and dissemination to unit staff. The CNS cochairs maintain the focus of the subgroup as they work and move the completed documents through the processes of document approval and posting on the intranet.

Although master's degree preparation exposes the CNSs to research methods, at the time of the initial formation of the CPC, few of the cochairs had any formal training in EBP. Structured orientation, regular cochair meetings, and ongoing support and education of the CNS cochairs were imperative in ensuring that the council was functioning as envisioned. Ongoing continuing education and support for CNS cochairs have been a process that required time, diligence, and effort but were vital to our success in transitioning from the traditional policy committee to an active, influential CPC.

Orientation of the CNS cochair includes a formal educational session with the director of research and EBP about the role of the CNS cochair, selection and development of documents, the approval process, and document dissemination strategies. Monthly cochair meetings, approximately 90 minutes in length, with the EBP mentors and the director provide ongoing mentorship support and education to the CNS cochairs. Cochair sessions prepare the CNS for the upcoming CPC meeting and allow the CNSs the opportunity to seek guidance and clarification of problematic areas of CPC document development and approval processes.

Within the department of nursing, advanced knowledge and skill building for the CNS cochairs and other leaders are available through the annual Advanced Leadership Institute. The Advanced Leadership Institute is an annual 8-hour workshop designed to develop the sophisticated skills necessary for administrative and clinical leaders to promote and mentor staff nurses and multidisciplinary teams in adopting EBPs. Content addressed in the Advanced Leadership Institute has included application of EBP models; retrieving and evaluating evidence; implementing, evaluating, and sustaining practice changes; and implementing system changes to facilitate and promote EBP throughout the health system. Additional content has included establishing the strength and level of evidence, synthesizing the evidence, and determining if the evidence supports a practice change. Several of the CNS cochairs received sponsored education outside the organization at a weeklong immersion program in EBP to further strengthen their knowledge and skills for leading the CPC.[14,16]

The CNS cochairs are dedicated to ensuring that nursing practice is supported by the latest evidence and guiding staff nurses to continually move their practice forward. The success of the CPC is due to the engagement of these clinical leaders.

IDENTIFICATION OF PRACTICE DOCUMENTS APPROPRIATE FOR THE CPC

The selection of appropriate practice documents for development or revision by the CPC is accomplished through a brainstorming process performed annually at the start of the fiscal year. The brainstorming process consists of 3 phases. During the first phase, nurses identify clinically important issues regarding inconsistent or ambiguous bedside practice. In the second phase, CPC nurses search and identify new or recently generated literature that is applicable to the selected topic/issue and warrants further investigation and consideration.

The process for searching the literature occurs by different council members and at different time points. Initially, the CNS cochair may do a more extensive literature search to bring potentially relevant articles for the group to review during the meeting. During meetings, the direct care nurses often do additional searching to fill in

any gaps. The librarians also help in the search process during meetings. The search process is done by seeking appraised sources of evidence first. Research studies, national guidelines, and at times nonresearch literature and expert opinion are sought and reviewed by this process. Systematic reviews with meta-analysis are the preferred sources for literature searches, followed by the various levels of research evidence, then clinical literature, then expert opinion.

During the third phase, each subgroup evaluates existing CPC documents that are due for review and considers requests from leaders for document development. The Iowa Model of Evidence-Based Practice to Promote Quality Care[17] is used as a framework for the initial brainstorming process described above and during the ongoing work of the council. For example, during the brainstorming process, the CPC representatives are asked to reflect on problem- and knowledge-focused triggers, which are steps in the initial phase of the Iowa Model.

The brainstorming process used by the CPC is preferential to developing a PICO question (population, intervention, comparison, and outcome), in that it allows the members of the subgroups to think more broadly about their practices. This is important in that each subgroup consists of different units with different patient populations. Thus, using the format of a PICO question would not be an optimal choice for the structure and processes used by the CPC.

Following the brainstorming process, the CPC nurses use the criteria listed in Table 1 to evaluate each potential practice document and generate a list of practice documents they will address for the year. The criteria help nurse representatives clarify which practice documents are appropriate for the CPC to address. For example, practice issues most appropriate for the CPC are those that are under nurses' domain, encompass multiple specialty areas, and do not require extensive multidisciplinary approval. In using this evaluation tool (Table 1), practice issues and documents are screened to ensure coherence with the structure and goals of the CPC and departmental priorities.

The CPC is respectful of practice areas predominantly under the domain of another discipline. When needed, the CPC consults with key stakeholders such as respiratory therapists, occupational therapists, nutritionists, and physicians. Thus, other disciplines participate in EBP activities with the CPC in an as-needed basis depending on the specifics of the practice documents. Each criterion in Table 1 is scored numerically by using 0 for not present, +1 for present/yes, and +2 for highly present/yes. The total score for the practice issue is calculated, and those practice documents scoring the highest are the focus of CPC subgroup work for the coming year.

Scoring leads to prioritizing practice documents and generates a list of 6 documents for each subgroup. The final list of the chosen practice documents that the CPC

Table 1. Evaluation Criteria for the Development of Potential Practice Document, Department of Nursing, Clinical Practice Council[a]

Criteria for Practice Document Selection	Practice Issue	Practice Issue	Practice Issue	Practice Issue
An existing practice document needs to be revised, updated, or combined with other documents and meets the criteria below				
The practice issue is important to the practice of staff nurses and daily patient care				
The practice issue is narrow in focus, predominantly under nursing domain, and can therefore be effectively accomplished by the structure and process of the Clinical Practice Council				
Addresses a practice that is a priority for the subgroup specialty area (eg, pediatrics, neonates, intermediate care, medical/surgical, or critical care) and the department of nursing				
Affects a significant number of patients				
Priority for the organization or meets regulatory agency requirements				
Existing body of research/evidence-based literature exists				
Authorship of the practice document has not been under the domain of a nurse specialist's responsibility (examples: pressure ulcer, central venous catheter care, restraints)				
Total score				

[a]*Scoring system: 0 = not present, +1 = present/yes, +2 = highly present/yes.*

Table 2. Sample Practice Document Development by Subgroups of the Clinical Practice Council

Pediatrics, neonate, and perinatal subgroup
• Glucose monitoring in the newborn
• Developmentally supportive care in the neonate
• Care of the pediatric patient on extracorporeal membrane oxygenation
• Skin-to-skin kangaroo care
• Oxygen therapy for the pediatric patient
Intermediate care: medical surgical subgroup
• Venus thromboembolism prophylaxis
• Chest tube management
• Care of the patient with a tracheostomy
• Cooling measures for treatment of fever
• Bowel management
Critical care: emergency subgroup
• Family visitation guidelines
• Transport of the intubated patient
• Intravenous insulin management
• Neuromuscular blockade
• Continuous cardiac output

will address for the year is e-mailed to the nursing leaders (Table 2). Unit leaders are notified monthly following each CPC meeting of the subgroups' progress and accomplishments regarding the current practice document being handled and representatives' meeting attendance.

The process just described ensures that the CPC's progress on the development of practice documents is reviewed by the leadership. The list of annual practice documents provides a template for the agenda for subsequent monthly meetings over the upcoming year.

PROCESSES USED DURING COUNCIL MEETINGS

The CPC meets monthly for 4 hours. The meetings enable active participation of members through the review of research and other levels of evidence, sharing of ideas, and consulting internal and external experts or departments as needed.

Each meeting begins with all the nurse representatives from the 3 subgroups present. New members and guests are introduced and welcomed. Subgroups report on the progress of their documents and the planned work of the day. A brief 30-minute education session related to EBP is presented (Table 3) by an EBP mentor, a CNS cochair, or a librarian. Afterward, the members break out into their respective subgroups to work on the practice documents planned for the meeting.

Working from the prioritized list of documents for the fiscal year developed through a previous brainstorming session, the nurses identify the clinical practice questions surrounding the practice document and the need for further evidence to support or change practice. The questions typically stem from noted differences in practice among individual practitioners or among different units, determining what best practice is, or noted uncertainty about a particular skill or equipment; for example, when working on the chest tube document, questions as to what is the best dressing for securing and preventing air leaks were raised. These questions helped to guide the search strategy for updating the practice document on chest tubes.

Research that supports or negates current clinical practice is reviewed and discussed. The evidence may include national guidelines, systematic reviews, meta-analyses, research articles, clinical articles, and expert opinion. Expert opinion is included when there is a dearth of research or literature support, and as appropriate. For example, when research evidence was lacking regarding valid and reliable instruments to assess risk of falls for pediatrics patients and a falls prevention guideline, the CPC representatives conducted a national inquiry of expert opinions.

The members appraise the evidence for its level, strength, and relevance to their population of patients. The selected evidence is compiled into a synthesis table. After organizing and summarizing the evidence, the members begin to develop or revise the practice document.

Table 3. Sample Educational Sessions for Development of Nurses on the Clinical Practice Council

• Levels of evidence
• Meta-analysis, systematic reviews
• Experimental study
• Quasi-experimental study
• Descriptive study
• National practice guidelines
• Finding and pulling the evidence together
• Evidence-based practice models
• Rapid critical appraisals/critique
• Guidelines, policies, and procedures
• Writing cognitive objectives
• Writing posttest questions

CPC-RELATED PRACTICE DOCUMENTS

Several types of practice documents are generated by the CPC: nursing policies and procedures, institutional nursing guidelines of care, clinical practice alerts, posttests for evaluating knowledge, and competencies. Each of these documents has a purpose and a format that is followed by all CPC subgroups. Table 4 lists the definition for each of the practice documents adopted by our institution on the basis of our review of the literature.

Levels of evidence supporting new practice changes or key existing practices are reflected in revised documents. For example, in a policy or institutional guideline of care, the acronym RNLE is used to reflect the level of evidence that is supported by research (R), national practice guideline (N), nonresearch literature (L), and expert opinion (E). The related citations for evidence-based interventions appear in the reference list at the end of the document in the reference format of the American Psychological Association. Figure 2 provides an example of a practice document that is an institutional guideline of care to meet the psychosocial needs of patients' families. The accompanying clinical practice alert is illustrated in Figure 3.

The wide variety of education and experiences of staff nurses regarding research and EBP necessitates this broad and simplified approach of the acronym RNLE to organizing levels of evidence. Nurses involved in the CPC are educated about the more detailed levels of evidence found in the literature and used by healthcare organizations. However, not all nurses within our healthcare system have this knowledge and thus find the simplified approach to classifying levels of evidence to be user-friendly.

In addition, the simplified approach to classifying levels of evidence fits well with the time constraints imposed by a 4-hour monthly meeting. Discussions regarding the level and appraisal of evidence and decisions to accept evidence are done in the subgroups led by the CNS, who are well versed in the intricacies of research and EBP.

APPROVAL AND DISSEMINATION PROCESS

Once the practice document has been drafted by the subgroup, the document is reviewed by the other subgroups that may be affected by the practice. For example, the document on psychosocial care of patients' families was authored by the critical care—emergency subgroup and sent to the intermediate care—medical surgical and the pediatrics, neonate, and perinatal subgroups for review and feedback. Suggested revisions with supporting evidence are returned to the authoring subgroup.

Thereafter, the CNS cochair sends the document to the leaders in the department of nursing at both institutions within the UCLA Health System for review and feedback. This fulfills one of the purposes of the CPC: to facilitate consistency of evidence-based nursing practices across the 2 hospitals within the UCLA Health System. Depending on the scope of the practice document, other persons with a stake in the process may be asked to review and give feedback. Feedback from individuals and committees is sent to the authoring subgroup. The subgroup reviews and considers their feedback and supporting evidence; revisions are made as needed.

The document proceeds to the department of nursing policy committees for approval. Upon approval, the policy or guideline is posted on the UCLA Health System intranet. The CPC members are notified of the document's approval, posting on the intranet, and readiness for dissemination to unit staff. To ensure accountability among CPC members, a confirmation of dissemination letter is sent to each representative to confirm dissemination; unit leaders are asked to corroborate the member's efforts.

The CPC was developed to engage our frontline clinicians in a structured effort to evaluate evidence and revise relevant nursing practice documents. At the time the CPC was launched, there was no interest in or financial support for purchasing a prepackaged program of polices and procedures. Our organization is in the process of evaluating the use of a prepackaged program of policies and procedures and thus far has found that these programs do not necessarily meet all our needs.

Dissemination

Collaboratively, all unit CPC representatives engage in disseminating and communicating new and revised practice documents and changes in practice to their respective units and throughout the hospital. As the CPC representative has reviewed the evidence to develop the nursing document, the representative has all of the background information for disseminating practice changes and the supporting rationales. Dissemination of this information to all direct care providers is critical in translation of the CPC's work into changes in care at the bedside.

Clinical Practice Council nurse representatives from each unit of the hospital are able to use specific dissemination strategies identified in collaboration with their CNS and unit leaders to meet the needs of their unit. Various strategies or combination of strategies is used at the unit level. For example, one unit may use the staff meeting forum to present the new practice document and ask nurses to self-evaluate their knowledge via the posttest. Another unit may use daily shift change huddles to highlight the new information and distribute the clinical practice alert that highlights the change in practice. Additional strategies may include using unit communication

Table 4. Definitions and Templates of Practice Documents

Document Type	Definition	Template Subheadings
Policy	A policy is a formal practice document that governs acceptable clinical practices and limits surrounding clinical practice. Specific organizational policies usually serve as the ''shoulds'' and ''thou shalts'' of agencies.[18] Although policies and procedures are often used interchangeably, policies are broader directives and may be incorporated at the beginning of a practice document for procedures. The policy document identifies who is qualified to perform a particular nursing procedure and under what circumstances these procedures are executed.	• Purpose • Policy • Scope • Procedure • Forms/related documents • References • Author contact • Publication and revision dates • Department approval signatures
Guideline	A guideline is a set of evidence-based recommendations for care of a patient population that is usually issued by a professional association, leading healthcare center, or government organization.[19] Guidelines assist in standardizing the management of disease states and are composed of current evidence-based knowledge and management strategies.	• The format is variable, depending on the organization or agency that has published the guideline. • Levels of evidence supporting specific interventions are usually reflected in the guideline.
Institutional guidelines of care	An institutional guideline of care is an agency-specific, evidence-based practice document that directs the assessment, interventions, and education of a specific population of patients within a specific institution.	• Patient goals/outcomes • Assessment • Interventions • Patient/family education • Forms/related documents • References • Author contact • Publication and revision dates • Department approval signatures
Nursing procedures	A nursing procedure describes a series of recommended actions or steps for completion of a specific task or function that a nurse performs while providing care to a patient.	• Delineates the steps of the procedure in a sequential manner
Clinical practice alert	A clinical practice alert is a 1- to 2-page document that summarizes the new or expected evidence-based practices reflected in new or updated institutional policies or guidelines of care. The clinical practice alerts are designed similarly to the practice alerts published by the American Association of Critical Care Nurses.	• Document number and title • Expected practice • Summary of evidence • Select references
Posttest	A posttest is a 5- to 10-item knowledge survey to evaluate the learner's knowledge regarding new or updated practices and their supporting evidence. The posttest is designed to cover critical information that is reflected in the institutional policy or guideline of care.	• Purpose • Objectives • Multiple-choice questions or case scenarios with questions
Competency	A competency is a set of prerequisite skills and psychomotor performance for high-risk and low-volume nursing practices that identifies the organization's level of satisfactory technical skill performance of nursing practices.	• A competency will be developed for select documents generated by the Clinical Practice Council that address high-risk and low-volume nursing practices.

boards that are located in every clinical area to post new CPC-related documents. A structure in conjunction with the communication boards such as online quizzes or a sign-off process ensures accountability for the information. Information may be presented at traditional staff meetings. Clinical Practice Council representatives may

Key: Evidence Practice Recommendations
R - Research
N - National Practice Guideline
L - Literature (Non-research)
E - Expert Opinion/Consensus

Psychosocial Care of the Family

SCOPE

This Hospital System Guideline applies to Santa Monica/UCLA Medical Center (SMUCLA) and Ronald Reagan/ UCLA Medical Center (RRUCLA). The Guideline does not apply to the Resnik-Neuropsychiatric Hospital.

Patient/Family Goals and Outcomes

1. Decrease or minimize psychosocial distress as evidenced by:
   a. Maintenance of family relationships
   b. Family's expression of both positive and negative concerns to their nurses
   c. Absence of inappropriate behavior (abusive, disrespectful, violent, etc)
   d. Participation in the decision-making process
   e. Seeking out resources
   f. Verbalization of a realistic view of the patient's condition
   g. Trust in their nurses
2. Patient/family will experience assurance, support, comfort and a healing connection with their nurses.

Research-based Knowledge

The results of numerous studies suggest that as a result of an acute/critical illness or hospitalization, family members exhibit a well-defined, predictable set of needs. These needs are grouped into 5 major areas and are universally experienced by most family members. **R[1,2] N[1,2] L[1]**

1. To receive **assurance**, reflecting a need to maintain or redefine hope about the patient's outcome.
2. To receive **information**, reflecting the goal of understanding the patient's condition.
3. To be in close **proximity** to the patient, reflecting a desire to link and maintain familial relationships.
4. To be **comfortable**, reflecting a need to reduce distress.
5. To have **support** available, reflecting a need for expert help, assistance, or aid.

In particular, stress and anxiety are increased when there is a lack of communication between the family and health care providers. Increased dependency, anger, and denial may be adaptive coping behaviors used in early stages of crisis until effective coping behaviors are learned. **R[1,2] N[1,2]**

Additionally, the research shows that nurses are challenged to balance care when attending to the patient's needs as well as the families' wishes and/or needs. **R [1] N[1] L [2]** Role expectations may be unclear; the nurse may experience conflict between their professional role and personal self. Investing oneself in the nurse family relationship is essential in building trust and developing a therapeutic relationship; however this personal investment can have disadvantages. **R [1]** The nurse experiencing challenging situations is advised to consult with the administrative leadership for further guidance in specific situations.

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Key: **R** = Research **N** = National Practice Guideline/Protocol
L = Literature (non-Research) **E** = Expert Opinion/Consensus

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L[2] Davidson, J., (2009) Family-Centered care: Meeting the needs of patients' families and helping families adapt to critical illness, *Critical Care Nurse*, 29 (3) pp 28-35

FIGURE 2. Example of a partial practice document and institutional guideline of care.

also use e-mail as an adjunct to communication; all direct care providers have a hospital system e-mail account and are able to access e-mail during their clinical shift. The CNS and the unit director or unit educator are available to support and mentor CPC representatives in the dissemination process.

One specific dissemination strategy is to use the Unit Practice Council structure. The CPC representative brings the nursing policy, procedure, institutional guideline of care, and practice alert information to the unit practice representatives to ensure their comprehension of the practice change and supporting evidence. As part of the role as a member of the Unit Practice Council, each member would be responsible for further dissemination to their assigned staff nurse colleagues, which would typically consist of 5 or 6 direct care nurses. The Unit Practice Council representative would also be responsible for eliciting questions or feedback and bringing this back through the shared governance structure. This process allows the CPC representative to present the information that is likely to be applied during that particular clinical shift and readily connect with a large number of direct care providers.

As liaisons between their units and the CPC, CPC representatives provide feedback to the council on the successful dissemination of the new information on their units. The CNS cochair facilitates the CPC representative's reporting the results of their dissemination and any challenges associated with the dissemination at the next CPC meeting.

IMPACT ON NURSING PRACTICE AND PATIENTS' OUTCOMES

A culture of inquiry is fostered at all stages of the processes used during council meetings as nurses are guided in reflecting on their current practices and seeking evidence to find new ways to improve patient care. The nursing department integrates select EBPs into the documentation system and performance improvement initiatives. The goal is to remind staff about practices, monitor compliance, and measure the effect on patient care and outcomes.

The following 2 examples demonstrate how the CPC has successfully engaged frontline clinicians in promoting nursing care that is evidence based and has produced improved practices to promote safe, effective care, and better patient care outcomes.

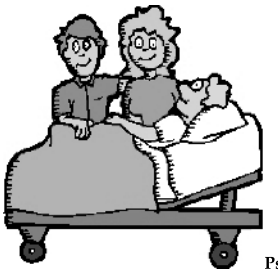
- *Example 2*. The CPC critical care subgroup reviewed the existing nursing practice documents related to drainage of cerebrospinal fluid via lumbar drains. New medical research and nursing literature revealed that it was necessary to revise current nursing practice to ensure safety of patients undergoing a thoracoabdominal aortic aneurysm repair. Changes included transducing the lumbar drain to the monitor and maintaining the patient on bed rest and in the intensive care unit while the lumbar drain was in place. The CPC facilitated the coordinated development of a specific physician order set for managing these patients that included the practice of transducing the lumbar drain to the monitor. Nurses were educated about the new practice changes regarding monitoring and drainage management in these patients, patient assessment, and when to notify the physician. Although no untoward patient events had occurred, the potential for a devastating outcome such as cerebral herniation leading to neurological deficits was prevented as a result of staff nurse representatives' evaluation of existing practice compared with the latest published evidence.
- *Example 2*. The adult intermediate care—medical/surgical subgroup and the pediatrics, neonate, and perinatal subgroup reviewed existing nursing practice documents related to the placement, assessment, and management of large-bore nasogastric tubes. Translating new research evidence regarding the accurate assessment and verification of placement of large-bore nasogastric tubes, the CPC members, in multidisciplinary collaboration, incorporated radiological confirmation of tube placement in adults and pH testing, as well as radiological confirmation when necessary, in neonates. The evidence cited in the CPC nursing policy resulted in being used by multidisciplinary leaders to create health system policy to reflect similar evidence-based recommendations and a change in practice throughout the entire organization based on the CPC's work.

In addition to the 2 examples of practice changes described, each practice document that is revised or developed based on research incrementally contributes to promoting safe, effective care and better patient outcomes. Efforts to instill EBPs significantly improved when staff nurses are involved in the process from the beginning. Fostering the participation of staff nurses in the process of clinical inquiry influences other important outcomes such as nurses' professional growth and development.

LESSONS LEARNED

The development and refinement of a CPC has progressed systematically for 5 years, and we have experienced obstacles, challenges, opportunities, and lessons learned. Strategies that continually strengthened the structure and processes of the CPC include the following:

- *Enhancing communication between CPC unit representatives and leadership*. Maintaining and using



UCLA Health System

Department of Nursing

Clinical Practice Council

Clinical Practice Alert

Psychosocial Care of the Family

The HS-NUR 1007 Psychosocial Care of the Family policy has been revised and contains some important changes that will affect your practice. Highlights of the changes are as follow:

Expected Practice:

1. Recognize that the 5 major needs of the family include assurance, information, proximity to the patient, to be comfortable, and to have support.
2. Use Active Listening techniques when interacting with families.
3. Assure families that measures are taken to promote patient's comfort.
4. Establish a family spokesperson and a system of patient identification such as the last 4 digits of the patient's medical record number or an agreed-upon password.
5. Encourage family members to rest, eat, and care for themselves. Showers for family members are available in North wing of some floors of the Ronald Reagan Medical Center. Family members should be made aware that they are responsible for providing their own supplies/toiletries.
6. Reassure family members that they will be informed of any transfer to a different room/unit or floor. The primary nurse is responsible to assure that the family is notified about the transfer.
7. Assess family's needs for additional resources (eg, social worker, chaplain, ethics, child life, translator). Take into consideration patient/family's language and cultural beliefs to prevent barriers in communication and care.
8. Assess the family's desire and ability to be involved in the patient's care.
9. Establish a trusting environment for patient and family by following the CICARE guidelines.
10. For sleeping and visiting arrangements adhere to unit-specific policies.
11. In general, families are encouraged to eat in designated areas and not in the patient's room; see your unit-specific policies.
12. Document in the electronic record the needs and concerns that were addressed.

Supporting Evidence:

The results of numerous studies suggest that as a result of acute/critical illness or hospitalization, family members exhibit a well-defined and predictable set of needs. In particular, stress and anxiety are increased when there is a lack of communication between the family and health care providers. **R**[1,2] **N**[1,2] The research also shows that nurses are challenged to balance care when attending to the patient's needs as well as the families' wishes and/or needs. **R**[1] **N**[1] **L**[2] Role expectations may be unclear; the nurse may experience conflict between his or her professional role and personal self. Investing oneself in the nurse-family relationship is essential in building trust and developing a therapeutic relationship; however, this personal investment can have disadvantages. **R**[1] The nurse experiencing challenging situations is advised to consult with the administrative leadership for further guidance in specific situations. **R**[1] **N**[1]

Need more information or help? Check with your unit's Clinical Practice Council representative, clinical nurse specialist/clinical educator, or unit director

Selected References
R = Research N = National Guideline L = Literature (Non-research) E = Expert Opinion

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N[1] Davidson, J. et al. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004 2005. *Critical Care Medicine,* 35(2): 605-622.

L[2] Davidson, J. (2009). Family-centered care: Meeting the needs of patients' families and helping families adapt to critical illness. *Critical Care Nurse*, 29(3): 28-35.

FIGURE 3. An example of a clinical practice alert. Format adopted from the American Association of Critical Care Nurses.

communication lines between the CPC representative, unit leaders, and staff are of utmost importance to ensure awareness of and accountability for practice changes. Continued regular reporting of the CPC's work in progress and attendance facilitates involvement of unit leaders despite competing demands. Dialogue between unit leaders and their CPC representative between CPC meetings, during document development and dissemination, enhances timely clarification of conflicting practices and preserves the collegial effort.

- *Strengthening the dissemination role of CPC unit representatives*. Dissemination is a key function of the CPC unit representative that requires ongoing supportive coaching and mentoring from unit leaders and CPC cochairs. A tracking mechanism has been implemented that includes confirmation of unit leaders that the CPC representatives from their unit have actively disseminated new practice changes in the unit. Some units have larger numbers of staff to whom information must be imparted. This situation raises the question of how many representatives from a unit are needed. Circumstances such as number of staff, complexity of the patient population, and finances influence that decision.
- *Ensuring consistency of CPC unit representatives at meetings*. To maintain continuity in developing a practice document from one monthly meeting to the next meeting, the representative obligation was increased from 1 year to 2 years. Extending the commitment ensures efficient development of practice documents and ensures that time is sufficient for the representative to experience the cycle of educational sessions, learn the group process, and become confident in the role of disseminator.
- *Balancing academic scholarship and the realities of clinical practice*. Thoughtful consideration of the depth of researching the evidence is necessary to balance the challenge of rigorous academic scholarship and the realities of using the clinicians' time efficiently and effectively. Clinical nurse specialist cochairs perform background work between meetings to prepare and run an efficient and effective meeting. Clinical nurse specialist cochairs have refined the process of searching and screening the evidence to enhance effective use of the CPC representatives' time during meetings. In the future, whether accessing commercially available practice documents that are based on the latest evidence is sufficient to guide the care of complex patients remains to be seen.
- *Enhancing the infrastructure for an effective meeting*. Environmental challenges that were overcome included locating suitable meeting locations and equipment. Requirements expand with increased membership and compete with other organizational initiatives. Limited access to meeting rooms, computers with Internet access, lavatories, and refreshments can disrupt the progress of the council meeting.

Future directions for strengthening and developing the CPC include evaluating the following:

(1) experience and level of satisfaction of the nurses involved in the CPC,
(2) circumstances and frequency of using CPC-produced documents for clinical decision making, and
(3) effectiveness of select practice documents on patient outcomes.

CONCLUSION

Improving staff nurses' professionalism through increased use of leadership behaviors, autonomous practice, and the ability to influence patients' outcomes positively through the use of evidence-based principles can be achieved by providing frontline clinicians with a framework to achieve these outcomes.[20] Success of the CPC depends on the CNSs' leadership and commitment in mentoring staff nurses in the process of developing EBP documents.

The CPC provides a structure and mechanism through which staff nurses can participate and contribute their clinical expertise, an essential component of EBP, to nursing documents, expand their role as leaders, and use the latest evidence to achieve the best outcomes for patients.

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