



structure.
process.
outcomes.

MAGNET MONDAY

FEBRUARY 4, 2013

MGH Site Visit:
March 4-7, 2013

Magnet Lunch Forum
12-1pm, every Thurs.
(lunch provided)

An opportunity for leadership, Collaborative Governance champions and other staff to learn more about Magnet Recognition and the *Magnet Monday* topic-of-the-week.

Evidence-based Practice (EBP) vs. Research vs. Process Improvement (PI): Key differences and examples

Nurses in Magnet organizations are committed to evidence-based practice in the provision of safe, effective, patient-centered care. At MGH, generating, identifying, and translating new and emerging knowledge are at the core of our four-pronged mission as an academic medical center—practice, education, research, and community. The first guiding principle states, “*We are ever-alert for opportunities to improve patient care; we provide care based on the latest research findings*” (Patient Care Services Guiding Principles).

What are the differences between EBP, PI, and Research?

	Process Improvement (PI)	Evidence Based Practice (EBP)	Research
Definition/purpose	To improve work flow processes, productivity, costs, systems and quality	To make a clinical decision based on best evidence, clinician's expertise, and patient's preferences and values	To generate new knowledge through a scientific process
Goal	Achieve greater quality and efficiency	Achieve best clinical outcome for a patient	Develop new knowledge that is generalizable to other persons/settings
Examples of Processes Used	Lean, Six Sigma, Plan-Do-Check-Act (PDCA)	Iowa Model of EBP to Promote Quality Outcomes	Randomized controlled trials (RCT); focus groups; surveys
Illustration of the Three Processes	<ul style="list-style-type: none"> Implement just-in-time system to ensure pneumatic boots are stocked and ready for use in the SICU 	<ul style="list-style-type: none"> Write and implement a policy for the use of pneumatic boots for gynecologic surgery patients based upon a systematic review of the literature. 	<ul style="list-style-type: none"> Conduct an RCT to determine whether compressions stockings or pneumatic boots are more effective in preventing DVT among gynecologic surgical patients
Generalizability	Unit-specific	Patient Specific	Population Specific

What is an example of EBP versus research?

EBP: Temporal Artery Thermometer

Two years ago, clinicians participating in advanced EBP training questioned the accuracy of temporal artery thermometers (TATs) because the readings from the TATs did not correlate with readings from

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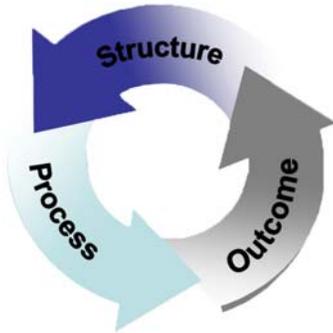
Next week's topic: "Resources to Promote EBP Research & Ethical Decision Making"



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Donabedian, 1966; 1990
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oral thermometers. They decided to use this question as the basis for an EBP project. They first confirmed that TATs are correlated to core body temperature at MGH, which explained the discrepancy. But, they wanted to learn more. They formulated an EBP question which guided an exhaustive literature review. “In the adult inpatient population, does the temporal artery thermometer (TAT) compared to the pulmonary artery thermistor (PAT), considered to be the gold standard, provide an accurate and precise measure of core body temperature?” The literature confirmed the reliability of the thermometers in normothermic and hypothermic patients but they found insufficient evidence that the TATs were reliable in the hyperthermic patients.

Next Step is Research: Temporal Artery Thermometer

The findings provided the impetus for a research study, Comparison of Temporal Artery to Pulmonary Artery Thermistor Temperatures in Hyperthermic Patients which is being conducted by a small team of researchers in the CSICU. The study compares temperatures taken by the TAT to pulmonary artery thermistors in febrile patients. In this situation, the clinical question generated an EBP project; insufficient evidence existed supporting the need for clinical research to determine the accuracy and precision of the TAT.

What is an example of Process Improvement at MGH?

Reducing Time from “Admission to Chemo” Hematology/Oncology Unit (Lunder 9)

Lunder 9 is a 32-bed Medical Oncology Unit that averages ten planned admissions for chemotherapy a week. The team enlisted the innovations specialist in the Center for Innovations in Care Delivery and established a goal of safely decreasing length-of-stay for its patient population by 10%.

The team focused on the admission process where they identified a delay between time of admission to the induction of chemotherapy (“admission to chemo”). The mean wait time for admission to chemo at baseline was 8.78 hours. The team set a goal of reducing the time by 20%.

The team and the innovations specialist engaged the ambulatory oncology practices in discussions to help understand all of the potential causative factors and strategies. A standardized, pre-admission process was implemented to ensure all patients have undergone laboratory tests, assessments, and that chemotherapy orders are written prior to admission. Implementation of this new process reduced the admission to chemo time by an average of 4 hours, which has been sustained for the last 13 weeks.

For more information on Evidence-Based Practice, Research, and Process Improvement, please visit the Excellence Every Day portal at: mghpcs.org/EED_Portal/EED_evidence-based_practice.asp

For more information, visit mghpcs.org/PCS/Magnet