



Editorial: Knowledge Translation into Practice: Models and Theories

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EDITORIAL: KNOWLEDGE TRANSLATION INTO PRACTICE: MODELS AND THEORIES

This editorial starts with a disclaimer that the opinions expressed within are not those of the publisher, my employer, or my profession. That being stated, I would like to describe some of my observations about implementing evidence-based practice (EBP) in nursing. These observations are culled from my experience over the years in attending (and giving) conferences and workshops related to evidence-based practice as well as working with nursing staff in several healthcare institutions as they have attempted to operationalize evidence-based practice.

Observation #1: We obsess about finding the “best evidence,” but don’t always make it to the finish line

I have become convinced that it’s easier to discuss finding and evaluating the evidence than it is to discuss what to do with the evidence once it is found. An example of this is the widely cited study that was first published in the *American Journal of Nursing* in 2005 (Pravikoff, Tanner, Annelle, & Pierce). The survey, which was sent to 3,000 nurses nationwide, addressed the first steps of the EBP process—that of being able to effectively locate and evaluate existing evidence. The authors reported data from clinically based registered nurses, which represented a 25.3% return rate. The survey results focused on the information needs and information-seeking skills of nurses and the barriers to using or obtaining these skills. As these are the first steps in the EBP process, obviously if there are problems here, one cannot easily advance to the next phase of implementation. However, in the years following this study, few, if any, investigators have addressed the readiness of nurses to address the “next steps” in the process (Cadmus, Van Wynen, Chamberlain, Steingall, Kilgallen, Holly, et al., 2008). The reason for this may be related to Observation #2.

Observation #2: We don’t always clearly articulate the relationships among evidence-based practice, quality assurance, and performance improvement

In working with staff nurses from several institutions, it becomes apparent that they still are confused as to how EBP, quality assurance,

and performance improvement “fit together,” and they don’t seem to “get” the concept that these processes should articulate to create a seamless whole. Reasons for this confusion may, in part, be related to Observation #3.

Observation #3: We need to be clearer about existing conceptual models and theories of evidence-based practice

At the risk of offending some readers, it seems that only one conceptual model fully articulates the broad process of knowledge translation into practice. This model, known as the ACE Star model of knowledge transformation (Stevens, 2004), is a parsimonious model that uses five steps to convey the translation process:

- Discovery (knowledge generation),
- Evidence Summary (production of a succinct summary of the evidence),
- Translation (translation of evidence summaries into clinical guidelines, protocols, and algorithms),
- Integration (planning and execution of an implementation process), and
- Evaluation (use of quality assurance data, and performance improvement processes if outcomes are not as predicted from the evidence).

In my practice, use of this model with nursing staff has made it very clear where the activities inherent in research, quality assurance, and performance improvement fit into the process of translating knowledge into practice, a.k.a. “doing” evidence-based practice.

Once the model is understood, using a theory, such as the Promoting Action on Research Implementation in Health Services (PARIHS) model (Kitson, Harvey, & McCormack, 1998a, 1998b; Rycroft-Malone, 2004; Rycroft-Malone, Kitson, Harvey, McCormack, Seers, Titchen, et al., 2002); the Ottawa Model of Research Use (OMRU) (Logan & Graham, 1998; Logan, Harrison, Graham, Dunn, & Bissonnette, 1999); or the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler, Kleiber, Steelman, Rakel, Budreau, Everett, et al., 2001; Titler, 2007) to actually incorporate evidence into practice begins to make sense. For example, the Iowa Model of Evidence-Based Practice to Promote Quality Care clearly lays out the “how to” of evidence-based practice through use of flowcharts and algorithms. Once the “big picture” that is conveyed by the model is understood, using one of these theories to serve as a guide to actually put evidence into practice is not seen as intimidating by nursing staff. All of these theories fit very nicely into the model of knowledge

transformation. Choosing one to use then becomes a matter of which best fits the institutional culture and its resources.

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Editor

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