THEORETICAL AND EXPERIENTIAL PERSPECTIVES ON FACILITATING EVIDENCE-BASED PRACTICE IN NURSING: TOWARD A CONCEPTUAL FRAMEWORK

by

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Abstract

The Issue: The integration of evidence into practice is a complex process. Facilitation is a strategy that may assist practitioners with enhancing evidence uptake in nursing practice. However, the concept is not well understood from a front-line nursing perspective.

Thesis Objectives: To describe facilitation in moving evidence into nursing practice and determine the nature of the facilitator role and the process of facilitation in theory and from actual experience to develop a conceptual framework to guide practitioners.

Methods: A descriptive design utilizing mixed methods was employed: 1) Focused review of the literature that synthesized the current state of knowledge on facilitation as role and process in the implementation of evidence-based practice (EBP) in nursing. 2) Case audit and focus group interview with facilitators of cases involved in adapting guidelines and planning for implementation.

A provisional framework was developed based on the literature review which guided the case audit and focus group interview. The data from the literature was integrated with data from those actively involved in facilitation to refine the framework.

Results:
Focused literature review: A final set of 39 papers were identified. Facilitation is described as supporting and enabling practitioners to improve practice through evidence implementation. Certain aspects of the role and the strategies being employed to promote change are evident. Current literature reveals that facilitation is viewed as an individual role as well as a process involving individuals and groups.
Case audit and focus group interview: Forty-six discrete, practical facilitation activities discovered in the literature were in large part found as occurring within the cases. An additional 5 new, distinct activities related to facilitation were found in the case documentation. Findings suggest that facilitation is a multifaceted process and a team effort. Communication and relationship-building are key elements.

Conclusion: The transparency and detail displayed in the revised framework may contribute to systematically developing, implementing, and testing facilitation interventions in nursing contexts. Facilitation is clearly an important strategy to advance EBP and the improved understanding of facilitation offered in this thesis provides a guiding framework for future investigations of evidence implementation where facilitation is a key element.
Co-Authorship

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CHAPTER ONE

Introduction

The quest for ‘best’ practices is a mantra in today’s health-care system. A key element is the integration of available evidence into practice. My interest in this topic evolved during my work as a registered nurse on an acute medical unit at a hospital in Western Canada. An initiative was introduced in order to implement evidence-based patient-teaching tools and documentation for use by nurses. Despite multiple implementation strategies utilized, such as one-on-one teaching with the nurses and incorporating reminder systems into patients’ charts, the implementation effort was unsuccessful. The organization invested significant time and resources into making the initiative work. What perplexed me was why it had failed and what could have been done differently. I undertook this thesis to explore what it is that contributes to and enables successful integration of evidence into nursing practice.

Implementation research in nursing is evolving with many different change strategies utilized at the point of care to assist nurses with the uptake of the latest research evidence in daily practice. However, moving evidence into practice from peer-reviewed journals and the recent innovation of practice guidelines remains a challenge. Despite advances in tailoring evidence for practice with specific clinical recommendations, research reveals that not all guidelines are effectively taken up in practice as the experience in my work setting reflects. As an example, an observational study of general practitioners conducted by Grol et al. (1998) found that guideline recommendations were followed, on average, in only 61% of clinical decisions. The situation may be similar in nursing.

In the past decade, the field of evidence-based practice (EBP) has shifted from a focus on the evidence and methods for rigorously synthesizing and translating study results into practice recommendations toward evidence implementation. Evidence suggests guideline adherence is
poor without specific interventions (Bauer, 2002). Research into changing practice to reflect best available evidence is an important health services and practice area of enquiry. A number of change strategies and change-agent roles are reported in the literature but several authors note overlap among them, suggesting that the division remains unclear (Harvey et al., 2002; Thompson, Estabrooks & Degner, 2006).

One such strategy that is considered an essential component to enabling successful implementation of research into practice is facilitation (Kitson, Harvey & McCormack, 1998). Theoretically, it is described as a technique whereby facilitators provide support to help individuals and groups realize what they need to change and identify how to make these changes to incorporate evidence into practice (Kitson et al.). Facilitation has garnered a great deal of attention generally across disciplines. However, research is needed to differentiate and describe facilitation from a practical perspective and specifically, how it relates to evidence implementation in nursing. First and foremost, this is consequential if through EBP we hope to enhance patient outcomes. It is also important from a professional perspective as nurses are accountable to their regulating bodies for basing their practice on sound evidence.

My thesis focused on gaining a greater understanding of facilitation of evidence-based practice in nursing. In other words, I wanted to examine how it contributes as a means to bridge the gap between research and practice. The aim was to combine theoretical and practical perspectives on the concept to develop and refine a conceptual framework of facilitation. This investigation of both the theory and actual experience of facilitation provides insight into the dimensions of the facilitator role and the facilitation process and serves as valuable information to guide the design and evaluation of practical strategies promoting EBP in nursing. In this chapter, I will describe the format, issue, and background to the thesis, state the research objectives, explain how the thesis research was connected to a larger, ongoing Pan-Canadian knowledge
translation initiative, outline the content of the remaining chapters, and conclude with a
description of how this thesis contributes to the overall body of knowledge.

Format of Thesis

This thesis is presented in manuscript style. The manuscripts follow as Chapters 2 and 4
and are formatted based on the guidelines and requirements of the journals to which they have
been or will be submitted. Chapters 3 and 5 describe development and re-conceptualization of the
facilitation framework. Chapter 6 summarizes and concludes the thesis with an overall discussion
and presents implications for practice, policy, and research. Additional information and data are
contained in appendices and are referenced as such in each of the chapters.

Description of the Problem

Over the past two decades, there has been increasing emphasis on the provision of
appropriate, cost-effective, and efficient health care to ensure the best possible outcomes for
patients. This stemmed from notable variation in health-care delivery across settings. Due to
ongoing pressure on health-care funds and resources and the increased accountability of
professionals to provide quality patient care to the public, the trend continues. A prominent,
quality element was the emergence of evidence-based medicine defined by Sackett, Rosenberg,
Gray, Haynes and Richardson (1996) as:

The conscientious, explicit, and judicious use of current best evidence in making
decisions about the care of individual patients. The practice of evidence based medicine
means integrating individual clinical expertise with the best available external clinical
evidence from systematic research. (p. 71)

Evidence-based nursing is described as “an integration of the best evidence available, nursing
expertise, and the values and preferences of the individuals, families and communities who are
served” (Sigma Theta Tau International, 2005, para. 4). In both definitions, it is explicit that
health-care decisions should be made based on evidence while taking into account individual situations.

Research utilization literature in nursing dates back to 1972 with the number of publications increasing substantially through the 1990s (Estabrooks, Winther & Derksen, 2004). This corresponded with a 1997 report from the National Forum on Health in Canada stressing the need for a greater use of evidence in health-care decision-making (Members of the National Forum on Health, 2004). Simultaneously, growth in the development and dissemination of clinical guidelines to inform practice was occurring. As an example, the U.S.-based Agency for Healthcare Research and Quality (AHRQ), formerly known as the Agency for Health Care Policy and Research (AHCPR), contributed to the development of 19 practice guidelines for health-care practitioners between 1992 and 1996 (AHRQ, n.d.). In 1997, the agency introduced an initiative promoting EBP through the synthesis and translation of research findings (AHRQ, 2008). Similarly in 2000, the Canadian Institutes of Health Research (CIHR) was established with a clear mandate emphasizing the importance of creating and translating new knowledge into improved health for Canadians (CIHR, 2008). Between 2005 and 2006, CIHR invested over 650 million dollars in health research (CIHR). Although funding and resources invested in research has resulted in the continuous production of new knowledge, it may take one to two decades before research evidence is incorporated into routine clinical practice (AHRQ, 2001). As the EBP and knowledge translation agendas continue to evolve at national levels, there remains a large gap in health care between what is known and what is practiced (Davis et al., 2003).

General barriers to research use in nursing have been investigated over many years and there is considerable consensus in this area (Funk, Tornquist & Champagne, 1995; Glacken & Chaney, 2004; Hutchinson & Johnston, 2004; Kajermo, Nordström, Krusebrant & Björvell, 1998; Micevski, Sarkissian, Byrne & Smirnis, 2004; Parahoo, 2000; Parahoo & McCaughan, 2001;
Thompson, Chau & Lopez, 2006). Nurses identified insufficient time and resources to access research, limited experience with evaluating and critiquing research, difficulties understanding statistical analyses, and a perceived lack of authority to change practice as key barriers to research use. Given agreement on many of these barriers, Rycroft-Malone and colleagues (2004) note research in this area may be exhausted. Recognition of the barriers and facilitators is a first step that is necessary but not sufficient in the uptake of evidence. Integration of evidence into practice remains a poorly understood, complex process. Titler (2004) argues that further research should focus on developing and analyzing the effectiveness of interventions targeting identified barriers and enhancing the use of evidence in practice.

Bero et al. (1998) found that passively disseminating evidence to practitioners is relatively ineffective in influencing change. Other systematic reviews suggest that a multifaceted approach, designed to target multiple barriers, may be more effective than a single intervention alone (Grimshaw et al., 2001; Oxman, Thomson, Davis & Haynes, 1995). However, a recent review of the effectiveness of guideline dissemination and implementation strategies concluded that there is an imperfect evidence base supporting which strategies work depending on various circumstances (Grimshaw et al., 2004). The challenge that remains is in differentiating between the various types of interventions to determine their effectiveness. Many are complex, utilizing diverse methods, and the different concepts relating to knowledge transfer and translation are often used interchangeably (Bero et al., 1998; Graham et al., 2006; Thompson, Estabrooks & Degner, 2006).

Facilitation is emerging as a predominant means of encouraging evidence uptake in clinical practice across health-care disciplines and particularly in nursing. An influential group of researchers in the United Kingdom developed a conceptual framework suggesting that the successful uptake of research into practice is dependent on the relationship between three key
factors: the nature and level of the evidence, the quality of the context into which change is to be implemented, and the process of facilitation (Kitson et al., 1998). For successful implementation, the authors hypothesize that there must be a clear understanding of the evidence, the quality of the context and its ability to deal with change, and the type of facilitation required for a successful change process. Facilitators assist individuals or groups to recognize what they need to change in practice and how to move forward in carrying out what is needed to make these changes (Kitson et al.).

Further development of Kitson et al.’s (1998) framework resulted in a highly-cited paper by Harvey et al. (2002), which presented the findings of a concept analysis of facilitation across a range of health-care literature. Their findings support that facilitation involves helping others to change practice and the purpose of facilitation is described as “ranging from a discrete task-focused activity to a more holistic process of enabling individuals, teams and organizations to change” (p. 578). Facilitator roles are appointed and viewed as supporting but not directing or persuading (Harvey et al.). In their review, they found a small number of evaluative studies where facilitation had an influence on changing organizational and clinical practice but no conclusions could be drawn due to limitations in study design and rigour. At issue are the limited descriptions of the concept and lack of rigorous evaluations of facilitation interventions. In summary, Harvey et al. concluded that the concept of facilitation is partially developed and further research is needed to describe and illustrate how it relates to evidence implementation.

Despite wide recognition and application of the concept across different disciplines and contexts including health care, education, and practice development (Cross, 1996; Harvey et al., 2002; Newton, 2003), facilitation has not been well defined. In particular, it has not been well explored from the perspective of front-line nurses as it relates to evidence implementation. Nurses are responsible and accountable for basing their practice on sound evidence according to
organizations’ and settings’ policies and the professional standards of their regulatory bodies. The governing body for nurses in Ontario specifies that nurses must ensure their practice “is based in theory and evidence” and must integrate “research findings into professional service and practice” (College of Nurses of Ontario, 2008, p. 8). This is consequential in moving to ‘best’ practices with the nature of typical nursing practice being 24/7 and nurses largely working in teams with a particular patient group.

Facilitation is a potential strategy for assisting nurses to implement evidence into routine practice. However, in nursing as well as other disciplines, there is a lack of consistent terminology describing the implementation methods used in implementation studies (Leeman, Baernholdt & Sandelowski, 2007). Stetler and colleagues’ (2006) qualitative evaluation of facilitation within six implementation projects concluded that it could be regarded as a distinct intervention such as audit and feedback and educational outreach. However, the authors expressed the need for further studies investigating the nature and effectiveness of facilitation in different types of projects to determine its contribution to successful implementation. For facilitation to be a useful element in the implementation of evidence in nursing practice, the concept needs to be categorized and defined operationally in order to plan and rigorously evaluate it as an intervention.

Thesis Objectives

The purpose of this thesis is to describe facilitation in moving evidence into nursing practice and to determine the nature and dimensions of the facilitator role and the process of facilitation in theory and from actual experience. A descriptive design utilizing mixed methods, including an integrative study, multiple-case audits, and a focus group interview, was employed to address the research aims. Divided into three phases, specific objectives were to:
PHASE 1: Clarify the state of knowledge

1. Synthesize the understanding of facilitation of EBP in nursing from major authors, researchers, and theorists through an integrative review of the literature;

2. Develop a provisional conceptual framework based on these perspectives of facilitation;

PHASE 2: Explore and describe an actual, active experience of facilitation

3. Utilize the provisional framework to explore the facilitation activity occurring in a Pan-Canadian initiative on evidence use;

PHASE 3: Refine the framework to reflect the theoretical understanding as well as the actual experience of facilitation of EBP in nursing

4. Determine the congruence between the theory/research-based understandings of facilitation and the actual, practical experience of facilitating EBP in nursing. Integrate data from the literature with data from those actively involved in facilitation to confirm and/or refine the provisional framework.

5. Develop practice and policy recommendations for nursing settings interested in active facilitation of EBP.

The enquiry was iterative with the phases building on and informing one another. The theoretical and experiential perspectives were integrated to formulate and refine the framework, which outlines the key elements and skills of facilitation of EBP in nursing. The thesis research was carried out alongside a natural experiment of active early adaptation and implementation of practice guidelines. The Canadian Partnership Against Cancer [http://www.partnershipagainstcancer.ca], also known as the Partnership, is a Pan-Canadian initiative supporting knowledge translation activity for improved care through guideline use
Facilitators assisted various groups in cancer care to adapt guidelines and plan for implementation.

The overarching framework for the thesis study was the Canadian Institutes of Health Research knowledge-to-action (KTA) framework published by Graham et al. (2006). This framework also guided conceptualization for the Partnership knowledge translation initiatives, including the guidelines adaptation project. Moving knowledge into action involves two major components: knowledge creation and the action cycle, each with different phases as illustrated in Figure 1. The “funnel” (Graham et al., p. 18) in the center of the framework represents knowledge creation whereas the surrounding action cycle relates to the activities and processes used in the application of knowledge. The guideline adaptation occurring within the Partnership bridged these two components. Guideline adaptation is knowledge creation in that a guideline was adapted for local use. Adaptation also spans the start of the action cycle as the process of adaptation is part of the implementation or action element. The bottom half of Figure 1 displays the KTA framework including the Partnership guideline adaptation components. Facilitators assisted groups through this process.
Figure 1. The knowledge-to-action (KTA) process.
Figure 1. (continued).


Data collected as part of the larger Partnership project was accessed in addition to data collected specifically for the purposes of this thesis. The thesis research objectives are addressed in the chapters as outlined below:

Chapter 2: Facilitation as a role and process in achieving evidence-based practice in nursing: A focused review of concept and meaning

The state of knowledge regarding facilitation was assessed in a review of published theory and research-based literature focused on facilitation as a role or process in research utilization or the implementation of EBP in nursing. The intent was to determine how the concept is used and described with a focus on the practical elements and what it entails to operationalize and implement facilitation in nursing. The review resulted in a set of theoretical and empirical papers (n = 39) with information on the role of facilitators and the process of facilitation. Papers were examined for descriptions of the meaning of facilitation, the characteristics and skills of facilitators, and the effectiveness of facilitation interventions.

This integrative study was submitted to the Worldviews on Evidence-Based Nursing journal as a literature review and is currently under review. Elizabeth J. Dogherty was primarily responsible for the development of the review including the design, analysis and interpretation, and initial draft of the manuscript. Co-authors, Drs. Margaret B. Harrison and Ian D. Graham, contributed to conceptualization of the paper, critique of the analysis and synopsis of findings. All provided editorial contributions and approved the final version of the manuscript.
Chapter 3: Conceptual Framework Development

This chapter addresses the second thesis objective and describes the initial conceptualization of facilitation based on the findings of the review. The results of the review provided the theoretical understanding of facilitation and what limited empirical knowledge there was available. This informed the development of the initial provisional framework of facilitation of EBP in nursing. This iteration of the framework is presented as well as a description of how the framework guided the research and informed the methodology. Development of an audit tool for use in the facilitation case study is described and presented.

Chapter 4: A mixed-methods study of the role and process of facilitation in a natural experiment of guideline adaptation and early implementation

The second manuscript addresses thesis objective 3, which was to explore the facilitation occurring in a Pan-Canadian initiative on evidence use through case audit of a purposive sample of 3 nursing-focused cases involved in the Partnership study. This chapter describes the larger initiative and embedded facilitation study focusing on the early steps of implementation, particularly in the selection of a guideline(s) and the guideline adaptation process. The methods and results of the audit from the case series and a focus group interview with facilitators in the field are described. In the focus group interview, facilitators involved in the Partnership study reported their experience and perceptions of the key elements of facilitation and commented on the results of the case audit. Analysis of the data was guided by the provisional framework. The aim in conducting this study was to expand the limited knowledge of facilitation in the context of changing nursing practice found through the aforementioned focused literature review.

Elizabeth J. Dogherty and Dr. Margaret B. Harrison conceived of the study and participated in the design. Elizabeth J. Dogherty was primarily responsible for study coordination, data collection, analysis and interpretation, and initial draft of the manuscript and subsequent
revisions. Dr. Margaret B. Harrison provided initial and ongoing refinements to the manuscript as well as critique of the data analysis and interpretation and synopsis of findings. Co-authors Drs. Ian D. Graham and Cynthia Baker provided feedback on the study design and contributed to conceptualization of data analysis. Both will critique the data analysis and interpretation and synopsis of findings. All authors will provide editorial contributions and read and approve the final manuscript prior to submission.

Chapter 5: Revisiting and Reconceptualising Facilitation

This chapter addresses the fourth research objective and describes how the provisional framework further evolved based on review of the case study and focus group interview data. As part of the focus group interview, facilitators involved in the Partnership study reported their impressions of the provisional framework. In this chapter, I describe how the theoretical and empirical understanding gathered from the literature was integrated with data from those actively involved in facilitation to refine the provisional framework. The revised framework is displayed, representing a comprehensive view and understanding of facilitation of EBP in nursing from both theoretical and experiential perspectives.

Chapter 6: Summary and Implications for Practice and Future Research

The final chapter integrates and summarizes the results of the thesis research and identifies implications for practice and policy as well as areas for future research to advance the facilitation of EBP in nursing. Recommendations for nursing settings interested in active facilitation of EBP were developed and are presented.

Contribution to Knowledge

Facilitation is recognized as an important strategy in knowledge transfer and evidence uptake. This thesis contributes to the knowledge and improves the understanding of facilitation, as a role and process, as it relates to evidence implementation in nursing. The description and
synthesis of the research literature will be useful to practitioners as a synopsis of the current state of knowledge in two ways: first, it updates the influential concept analysis by Harvey et al. (2002) which contained literature published to 1998 and secondly, it adds a practical, ‘how-to’ perspective on facilitation. The research contributes to the understanding of the concept of facilitation through integration of the theoretical perspectives from the literature and the actual, practical perspectives gathered from both case-audit data and a focus group interview with those actively engaged in facilitation of EBP. The framework resulting from the thesis enquiry provides a useful model and guide for practitioners and organizations as it characterizes the structure of facilitation and articulates the broad and seemingly essential components of the process. Importantly, the research advances the understanding of facilitation, particularly into the dimensions of the role and process. This will assist practicing nurses and nurse managers in using strategies to bridge the gap between research and practice, and ultimately improve patient care.

From this research, the groundwork is laid for the design and evaluation of practical strategies for EBP in nursing. In completing this work, I am convinced that facilitation is a key element and an area that I hope to continue evaluating and researching in my PhD studies.
References


CHAPTER TWO

Facilitation as a role and process in achieving evidence-based practice in nursing:
A focused review of concept and meaning

[Submitted to Worldviews on Evidence-Based Nursing on July 7, 2009 for review]

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Abstract

Background: Facilitation is proposed as an important strategy to assist practitioners to implement evidence into practice. However, from a front-line nursing perspective, what is actually involved in facilitation is poorly understood.

Aim: To examine the current state of knowledge surrounding the concept of facilitation as a role and process in the implementation of evidence-based practice within the context of nursing. Building on a previous concept analysis, we examined how facilitation has evolved over the last decade, particularly focusing on the practical elements (e.g. what it entails to operationalize and implement facilitation in nursing).

Methods: A systematic search of electronic databases identified theory and research-based nursing papers explicitly focused on facilitation in research utilization or the implementation of evidence-based practice. Through a content analysis, we examined how the concept is being used, described, and applied within nursing.

Results: Facilitation continues to be described as supporting and enabling practitioners to improve practice through evidence implementation. Certain aspects of the role and the strategies being employed to promote change are more evident. It was possible to formulate these into a taxonomy. Key findings include:

- facilitation is now being viewed as an individual role as well as a process involving individuals and groups;
- project management and leadership are important components;
• no specific approaches appear superior but tailoring facilitation to the local context is critical;
• there is growing emphasis on evaluation, particularly linking outcomes to nursing actions.

Conclusions: Further understanding of what facilitators are actually doing to enable changes in nursing practice will provide the groundwork for the design and evaluation of practical strategies for fostering evidence-based practice in nursing. Research is needed to clarify how facilitation may be used to implement change in nursing practice along with evaluation of the effectiveness of various approaches.

Keywords: facilitation, evidence-based practice, research utilization, research use, research implementation, nursing practice
Background

Facilitation is emerging as an important concept in evidence uptake in clinical nursing practice. It is viewed as a means of bridging the gap between theory and practice. Kitson, Harvey, and McCormack (1998) developed a conceptual framework proposing that facilitation, in addition to the nature of the evidence and the quality of the context, is an essential component enabling successful implementation of research into practice. Facilitation is presented as a technique whereby facilitators provide support to help individuals and groups realize what they need to change and identify how to make these changes to incorporate evidence into practice.

In further developing the framework, Harvey et al. (2002) conducted a concept analysis of facilitation across a range of health-care literature published between 1985 and 1998. Their findings support that facilitation involves helping others change practice with the purpose of facilitation “ranging from a discrete task-focused activity to a more holistic process of enabling individuals, teams and organizations to change” (Harvey et al., p. 578). Facilitation effectiveness is poorly understood. Harvey et al. found facilitation has some influence on changing organizational and clinical practice but findings are equivocal. At issue are the limited descriptions and lack of rigorous evaluations of facilitation. In summary, Harvey et al. concluded that the concept of facilitation is therefore partially developed and further research is needed to describe and illustrate how it relates to evidence implementation.

To explore the concept’s maturity, we undertook this enquiry to understand how the nature of facilitation has evolved over the last decade, especially given rapid advancements in the field of implementation science. From Harvey et al.’s (2002) analysis, it is apparent that the meaning and application of facilitation varied depending on the applied field. It can be used generally within education and practice development and specifically for implementation of evidence-based practice (EBP). From a pragmatic, point-of-care perspective, there is a need to
clarify how facilitation plays out in a nursing situation. Therefore, the scope of this review is purposefully limited to facilitation related to evidence implementation in nursing. An important focus of the current review is particular attention to the practical elements of the concept and what is entailed to operationalize and implement facilitation.

Building on Harvey et al.’s (2002) previous analysis, we utilized a similar approach to examine recent literature for descriptions of the meaning and purpose of facilitation, the characteristics and skills of facilitators, and the effectiveness of facilitation interventions. We sought to understand generally how the concept is being researched, studied, and theorized to gather new insights into application. In examining the current state of knowledge about facilitation for implementation of EBP within the context of nursing, our objectives were to:

- Examine the discourse around facilitation in EBP in nursing literature as it has evolved since Harvey et al.’s analysis that focused on literature published between 1985-1998,
- Describe the strategies used in facilitation and develop a taxonomy of facilitation interventions,
- Explicate the characteristics and skills of facilitators involved in implementation of EBP and develop a facilitator role synopsis, and
- Determine the effectiveness of facilitation interventions involving nursing practice.

**Methods**

A multi-step approach was used to identify literature focused on facilitating EBP in nursing. We searched three computerized bibliographic databases to source relevant theory and research-based nursing literature. Similar strategies were replicated in each database using identical keywords and appropriate mapped subject headings (see Figure 2). References of retrieved articles were reviewed for potentially relevant citations, further extending the search. A decision tree was constructed with search and retrieval yields (see Figure 3).
Figure 2. Search strategy for CINAHL, EMBASE, and MEDLINE.

CINAHL

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EMBASE

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<td>professional development (MeSH)*</td>
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$ = truncated search term
mp = keyword
MeSH = mapped subject heading
* = explosion of subject heading
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<td>professional development (mp)</td>
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Figure 3. Search strategy decision tree. All databases were limited to date = January 1996 - May 2008 and language = English.

EMBASE
216

CINAHL
558

MEDLINE
314

# of titles screened - Online database yield (including duplicates)

# of abstracts screened (excluding duplicates)

# of articles screened (full text retrieved and reviewed)

NOTE: Duplicate articles were found across databases. MEDLINE was searched first and then CINAHL followed by EMBASE, accounting for the larger # of articles traced back to MEDLINE.

Total # of articles reviewed (15 + 31 + 47)

93

# of articles retrieved from reference lists of relevant articles meeting inclusion/exclusion criteria

10

# of articles included

39 (+ Harvey et al. 2002 analysis for a total of 40 articles)

# of articles excluded - not meeting inclusion/exclusion criteria

63
First, a broad search was done using the keywords ‘facilitation’ and ‘facilitator.’ This failed to generate relevant subject headings. These terms, in addition to ‘facilitate,’ comprise both nouns and verbs thus adding to the complexity of the search. Therefore, the truncated version of each term, ‘facilita$,’ was used to generate literature containing all three words. The search was limited to publications from 1996 onward to correspond with the guideline development and dissemination movement and advances in EBP within nursing in Canada, which became palpable in the mid-late 1990’s. There is a two-year overlap (1996-1998) with the Harvey et al. (2002) analysis.

Papers were included if they contained an explicit focus on facilitation as a role or process in research utilization (RU) or the implementation of EBP in nursing. Papers were excluded that dealt with: descriptions of general barriers and facilitators to RU, unless facilitation was outlined as a distinct process; nurse participation in research as opposed to actual research use; nurses’ attitudes and perceptions of research use; and facilitation interventions in which the changes implemented were not outlined as being based on research evidence.

It should be noted that ‘professional development’ was used as a keyword and subject heading to identify articles on facilitating evidence implementation as part of continuing education. However, in continuing professional development and education, the focus is on teaching practitioners and enhancing their competence whereas knowledge translation also concerns patients and health systems (Davis et al., 2003). Simply providing education may not result in actual behaviour change or research implementation. Therefore, articles focused on facilitating education with no mention of research use were excluded. The same criteria were applied to papers retrieved about ‘practice development’ (PD). As the concept is not well-agreed upon and a broad view of PD related to quality is acknowledged, this review focused specifically on articles referring to the implementation of research or EBP.
All titles were screened online and if relevant to the general aim of the review, corresponding abstracts were examined for eligibility using the inclusion/exclusion criteria. Abstracts of articles appearing to meet criteria were retrieved in full text for review. If an abstract was unavailable online, the full text was retrieved before deciding on inclusion/exclusion. During the screening process, two reviewers assessed papers using the criteria. Once the final set was agreed upon, the papers were examined to synthesize the understanding of facilitation of EBP in nursing. Synthesis tables were constructed to display the results relevant to the aims of the review. Appraisal of study quality was not undertaken as the focus was on the concept and how it is used in nursing. A simple content analysis was performed to determine descriptions of the meaning and purpose of facilitation, the characteristics and skills of facilitators, and the effectiveness of facilitation interventions.

Results

A large number of papers were identified (n = 1088) from the broad keyword search strategy. After screening for duplicates and applying the inclusion/exclusion criteria, a final set of 39 papers resulted (see Figure 3). In screening abstracts, the majority (63%) were excluded because there was no mention of facilitation as a role or process, or the focus was on general barriers and facilitators to research use (15%). Reasons for exclusion following full article review were tracked (see Table 1).
Table 1

Reasons for exclusion of full-text articles screened

<table>
<thead>
<tr>
<th>ARTICLES EXCLUDED (n = 63)</th>
<th>% (approx)</th>
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<tbody>
<tr>
<td>No specific focus on facilitation as a role or process</td>
<td>28</td>
</tr>
<tr>
<td>No focus on facilitating the implementation of evidence or research use</td>
<td>14</td>
</tr>
<tr>
<td>Facilitation in learning or education</td>
<td>7</td>
</tr>
<tr>
<td>No major focus on facilitation (only briefly mentioned)</td>
<td>4</td>
</tr>
<tr>
<td>No articulation of the facilitator’s role</td>
<td>4</td>
</tr>
<tr>
<td>Facilitation mainly focused on changing physician practice</td>
<td>4</td>
</tr>
<tr>
<td>Forum abstract</td>
<td>1</td>
</tr>
<tr>
<td>Article could not be obtained</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>63</strong></td>
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The final set included: research studies (17), frameworks (4), reviews (4), project descriptions (6), and discussion or commentary pieces (8) [NOTE: although counted individually for the purposes of this review, two research studies were associated with two papers each reporting different results from the same overall study. Three of the four framework papers discuss further developments of a single conceptual framework originally developed by Kitson et al., 1998].

The Understanding of Facilitation

Definitions of facilitation provided by Kitson et al. (1998) and Harvey et al. (2002) continue to be predominantly cited by others. In the literature published since, one other explicit definition was discovered (see Table 2). While Harvey and colleagues highlight the notion of making implementation easier, the more recent definition given by Stetler et al. (2006) emphasizes the importance of relationships and working together.
Table 2

**Definitions of facilitation**

<table>
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<tr>
<th>References</th>
<th>Definition</th>
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<tr>
<td>Kitson et al., 1998</td>
<td>“a technique by which one person makes things easier for others” (p. 152)</td>
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<tr>
<td>Newton, 2003; Owen &amp; Milburn, 2001; Wallin, Rudberg &amp; Gunningberg, 2005</td>
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<tr>
<td>Harvey et al., 2002</td>
<td>“the process of enabling (making easier) the implementation of evidence into practice” (p. 579)</td>
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<tr>
<td>Alkema &amp; Frey, 2006; Doran &amp; Sidani, 2007; Ellis, Howard, Larson &amp; Robertson, 2005; Scott &amp; Snelgrove-Clarke, 2008</td>
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<tr>
<td>Stetler et al., 2006</td>
<td>“a deliberate and valued process of interactive problem solving and support that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship” (para. 4)</td>
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In general, implementation research involving facilitation does not provide specific definitions of the term but it is viewed as a method for assisting with quality improvement in practice (Loftus-Hills & Duff, 1997). Facilitators aim to support individuals and groups through the change process (Thompson, Estabrooks & Degner, 2006). This change is goal-oriented (Rycroft-Malone et al., 2004; Scott & Snelgrove-Clarke, 2008) and intermediaries, such as facilitators, assist and influence nurses to achieve predetermined objectives (Ferguson, Milner & Snelgrove-Clarke, 2004).

**Facilitation Strategies**

In line with Harvey et al.’s (2002) findings, facilitation reported in nursing in the intervening years is carried out by individuals assisting others to implement evidence into practice. Our content analysis revealed specific strategies involved in facilitation of EBP in nursing. We found commonalities across papers with five unique, overarching areas emerging:
In general, upon increasing practitioners’ awareness of a need for change, facilitators employ a variety of change strategies depending on the context where change is to take place. The process is iterative and occurs over a period of time with ongoing monitoring and support provided in progressing toward change. Within each of the five areas, the recent literature reveals unique, practical aspects of facilitation.

Increasing awareness of a need for change. As originally proposed by Kitson et al. (1998) and reiterated by Harvey et al. (2002), facilitators play an important role in helping people recognize and understand what they need to change. In implementation research and projects to date, this has typically been accomplished through a practice evaluation by formal or informal audit and feedback (Jones et al., 1996; Loftus-Hills & Duff, 1997; Ruston, 2002; Sipilä, Ketola, Tala & Kumpusalo, 2008). Practitioners may be unaware that care they provide is not based on current research or believe they are practicing in line with the evidence when, in fact, they are not. The subject of change may already be identified or facilitators may help staff recognize an area for change by stimulating critical inquiry into their practice (Pepler et al., 2005). In their multi-site case study, Loftus-Hills and Duff (1997) found that selecting a topic which was relevant to staff and recognized as a priority stimulated both interest and motivation. While performance gaps may need to be recognized to provide the impetus for change, Ferguson et al. (2004) suggest a more positive emphasis be placed on enhanced patient outcomes rather than evidence of poor practice.
Leadership and project management. Upon recognition of a need for practice improvement, an individual or team assumes leadership and responsibility for managing the change process. This responsibility may rest with a staff member or team at an organization or setting with an outside facilitator providing assistance to help them along the way (Ruston, 2002; Stetler et al., 2006; Wallin, Rudberg & Gunningberg, 2005), which is how the role was originally described. Alternatively, a facilitator from the site may take on the leadership role independently (Loftus-Hills & Duff, 1997; Owen & Milburn, 2001). Facilitators may come from within or outside an organization or setting, or sometimes a combination of both (Rycroft-Malone, Harvey, et al., 2002; Rycroft-Malone, Kitson, et al., 2002; Stetler et al., 2006). This is reflective of Harvey et al.’s (2002) findings. However, as Rycroft-Malone et al. (2004) note, regardless of whether internal or external, identifying a leader to drive implementation contributes to success. Emphasis also remains on the facilitator role being clearly defined and articulated (Stetler et al., 2006). This is important for organizations to consider from a practical and operational perspective. Identifying the appropriate person(s) to lead implementation projects and communicating their role may require more attention to increase the likelihood of success.

The nature of facilitation. Studies demonstrate variation across settings in whether facilitators are positioned on or off site (Alkema & Frey, 2006) and variation in outcomes even when facilitators adopted similar implementation approaches (Loftus-Hills & Duff, 1997). Facilitators in one study interpreted their role differently with one describing it as maintaining group motivation while another’s focus was addressing differences of opinion and helping staff identify problems (Loftus-Hills & Duff). Facilitators have integrated a range of implementation strategies including educational, epidemiological, organizational, behavioural, and social influence strategies (Wallin, Rudberg, et al., 2005) or were seen as likely to use other
implementation interventions (e.g. education) while providing support and problem-solving (Stetler et al., 2006).

This diversity of approaches in moving evidence into practice reflects the multifaceted nature of facilitation purported by Harvey et al. (2002), who also identified the need for a variety of strategies. In their analysis, they describe facilitation activities as occurring on a continuum ranging from distinctly task-driven actions to more holistic endeavours aimed at releasing “the inherent potential of individuals” (Harvey et al., p. 581). The primary purpose of facilitation effects its operationalization and in practice, approaches often include various activities spanning the continuum. In keeping with their observations, the recent literature describes facilitation as an intervention that may include coordinating and implementing other multifaceted interventions. Importantly, literature is now beginning to provide descriptions and some detail of the specific strategies involved.

Building on the project-management end of the continuum, facilitators assist groups in setting clear goals through development of an action plan for change (Owen & Milburn, 2001; Stetler et al., 2006). Administrative duties include organizing and facilitating meetings as well as gathering and disseminating information (Owen & Milburn, 2001; Tucker et al., 2006). In particular, knowledge translation and dissemination with end-users in a setting surfaced as a major facilitator role (e.g. developing or distributing and modifying or adapting guidelines in collaboration with practitioners) (Ellis, Howard, Larson & Robertson, 2005; Wallin, Rudberg, et al., 2005). It is noted that facilitators use and offer practical tools or resources but these materials are not described (Stetler et al., 2006; Wallin, Rudberg, et al., 2005).

Working together and building relationships are inherent in definitions of facilitation and representative of activities closer to the holistic end of the continuum described by Harvey et al. (2002). For greatest effect, emphasis is placed on engaging the whole team from the beginning of
the process (Marshall, Mead, Jones, Kaba & Roberts, 2001). The importance of the relationship between facilitators and practitioners and value of using a teamwork approach is noted across studies (Jones et al., 1996; Loftus-Hills & Duff, 1997; Stetler et al., 2006). The role often involves collaborating multi-professionally, crossing disciplinary boundaries (Jones et al., 1996; Ruston, 2002; Sipilä et al., 2008) or linking with outside experts (Stetler et al., 2006).

Mentoring staff is considered a strategy to raise research awareness and facilitate research use (Camiah, 1997; Pepler et al., 2006). In an exploratory, qualitative enquiry by Tolson, McAlloon, Hotchkiss, and Schofield (2005), “confidence-building” (p. 124) was a common thread throughout themes identified as facilitating best nursing practices. Increasing staff awareness of their resistance to research use and change, and helping them overcome it, is considered part of facilitation (Pepler et al., 2006; Wallin, Rudberg, et al., 2005) as well as carrying out everyday tasks taken on by the project lead (e.g. coordinating audits, assembling reports, planning and leading meetings, and problem-solving) (Rycroft-Malone et al., 2004).

In addition to studies, a number of discussion and review papers described knowledge dissemination and dealing with staff resistance (Regan, 1998), role-modelling (Eaton, Henderson & Winch, 2007), and enhancing relationships and communication (Nagykaldi, Mold & Aspy, 2005) as components of facilitation. One project highlighted how a facilitator fostered relationship-building through regular communication, promoting shared decision-making and consensus-building, recognizing staff efforts, and demonstrating flexibility (Tucker et al., 2006). Providing advice along with acquiring and translating knowledge to apply in practice were cited as major components of the facilitator’s role (Eaton et al., 2007). Clinical nurse educators perform literature searches and offer articles on selected topics as needed to facilitate RU (Milner, Estabrooks & Myrick, 2006). Nurses identified library science support in conducting literature searches, accessing, appraising, and summarizing evidence as facilitating EBP (Tod, Bond,
Leonard, Gilsenan & Palfreyman, 2007). The facilitator role and the process of facilitation involve multiple approaches and, as the recent literature reveals, may be performed by different individuals in various service roles (e.g. nurse educators, librarians, etc.).

Importance of the local context. A critical element seen consistently across articles is the importance of the local context. Context is one of the three original elements in Kitson et al.’s (1998) framework proposed as influencing successful implementation of research into practice. In a Canadian multiple-case study, Pepler and colleagues (2005, 2006) examined how nursing practice in the acute-care setting is based on research. What they found revealed variation in research use within and across units despite similar strategies facilitating research use being used by clinical nurse educators and clinical nurse specialists. They suggested variation related to differences in unit culture (e.g. the beliefs, values, and practice norms of the unit). Facilitators in emancipatory practice development encourage practitioners to become more aware of their practice culture and context (see Manley & McCormack, 2003 for further discussion). As well, the activity of helping practitioners “transform the practice environment so that the implementation context is conducive to change” (Rycroft-Malone, 2004, pg. 300) is likely part of the facilitator role.

In general, the facilitation approach depends on the characteristics and needs of the local setting where change is to take place. This was noted by Harvey et al. (2002) in that facilitators utilize various skills according to the context’s needs. However, in addition to using different skills, a repeating theme in recent literature is the notion of working with practitioners to tailor and adapt actual facilitation interventions and clinical practice guidelines (the evidence tool) to a local practice setting (Ellis et al., 2005; Jones et al., 1996). Adapting evidence to the setting creates a sense of local ownership amongst staff, which is important (Loftus-Hills & Duff, 1997;
Ruston, 2002). It is undoubtedly a necessary activity to ‘fit’ recommendations to the context and capability of a practice setting.

Henderson and Winch (2008) suggest that in implementation, evidence is integrated into the local context under the guidance of a facilitator. A problem-solving approach to research use applies information regarding the social and cultural context to select appropriate change strategies to overcome barriers (Winch, Henderson & Creedy, 2005). Clearly more attention is being given to facilitating research implementation in practice by tailoring approaches to a local context, a predominant factor to be taken into account. Certain approaches may or may not be effective within a single setting, let alone across settings.

**Ongoing monitoring and evaluation.** Following development and initiation of a tailored action plan, the facilitation process continues for a period of time. Facilitators organize meetings to assess progress and effectiveness of selected approaches and to provide ongoing feedback and support in addressing issues (Jones et al., 1996; Marshall et al., 2001; Stetler et al., 2006; Wallin, Rudberg, et al., 2005). Changes to the original plan may be necessary and in some cases, further education or training required (Marshall et al., 2001; Stetler et al., 2006). The meetings and coming together are important for motivation and continued action toward change, providing deadlines which stimulate practitioners to complete previously agreed-upon tasks (Marshall et al., 2001). Further, Loftus-Hills and Duff (1997) found regular meetings generated enthusiasm and feedback that helped practitioners recognize their accomplishments. Similar to Harvey et al.’s (2002) findings, there is variation within and across studies in the amount and length of follow-up based on groups’ needs.

Recent work offers a new focus on incorporating evaluations from various perspectives. Post-intervention audit has been utilized to evaluate practice change (Jones et al., 1996; Ruston, 2002; Sipilä et al., 2008). In evaluating outcomes, the ability of nurses to make the connection
between evidence and patient care is important for success in getting research into practice (Doran & Sidani, 2007; Pepler et al., 2006). Doran and Sidani went further and developed a knowledge translation framework concentrated on patient outcomes. Facilitation is one of four main components described, with advanced-practice nurses facilitating staff through provision of education and support in assessing patient outcomes and using research in their decision-making processes. In contrast, Ring, Coull, Howie, Murphy-Black, and Watterson (2006) found that nurses perceived improvements in the process of patient care, as opposed to patient outcomes, as the benefit of best practice statements. Acknowledging success of the group’s effort and also benefits to users may sustain motivation for continued change (Owen & Milburn, 2001). Both process and patient outcomes are likely important and nurses’ satisfaction with the process of care may serve as a proxy for improved outcomes.

Characteristics and Skills of Facilitators

There is a range of requisite knowledge and skills for those engaging in facilitation, adding to the earlier findings of Harvey et al. (2002). In implementation studies, facilitators may be given specific training (Loftus-Hills & Duff, 1997; Sipilä et al., 2008). In one study, facilitators were provided with an extensive education program including: treatment using the guideline, audit and feedback, interaction and motivation skills, and how to understand and lead change (Sipilä et al.). However, as Harvey et al. (2002) also found, aside from the description, there was little evidence as to how these skills are developed. In other cases, it seemed that individuals taking on facilitation had previous training, skills, or relevant experience (Stetler et al., 2006). We found that qualities of effective facilitators are described although not formally evaluated. Many of the skills and characteristics for effective facilitation were found in the conceptual and theoretical literature, project descriptions, and reviews (see Table 3).
Table 3

Skills and attributes of facilitators identified in research studies

<table>
<thead>
<tr>
<th>Ellis et al., 2005</th>
<th>Understanding of the practice context</th>
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</thead>
<tbody>
<tr>
<td>Loftus-Hills &amp; Duff, 1997</td>
<td>Innovative and resourceful, ability to maintain momentum and direction and to allocate roles and delegate responsibilities, and to give support and encouragement</td>
</tr>
<tr>
<td>Stetler et al., 2006</td>
<td>Credible, flexible in adopting different styles depending on the context, experienced, knowledgeable, committed, responsive, and good communication and problem-solving skills with an understanding of the local context</td>
</tr>
<tr>
<td>Wallin, Rudberg &amp; Gunningberg, 2005</td>
<td>Authentic</td>
</tr>
</tbody>
</table>

Additional skills and attributes of facilitators identified in other literature

Tact, sensitivity, provision of technical, practical, organizational, and emotional assistance, interpersonal and communication skills, consistent presence, availability, practice development, experience, comprehensive understanding of EBP, project and group management skills, flexibility, commitment, persistence, and negotiation skills

(Eaton, Henderson & Winch, 2007; Ferguson, Milner & Snelgrove-Clarke, 2004; Harvey et al., 2002; Henderson, Winch, Henney, McCoy & Grugan, 2005; Kitson et al., 1998; Richens, Rycroft-Malone & Morrell, 2004; Rycroft-Malone, Harvey, Kitson et al., 2002; Thompson, Estabrooks & Degner, 2006; Tranter et al., 2007)

Academic or government health-care organizations typically hire and train facilitators for specific projects (Nagykaldi et al., 2005) and individuals are appointed to the role (Loftus-Hills & Duff, 1997; Owen & Milburn, 2001; Tucker et al., 2006). The role does not impose certain ways of working on individuals (Jones et al., 1996), being neither prescriptive nor directive, but strives to help people recognize and attain their greatest potential (Thompson et al., 2006). Owen and Milburn (2001) describe a dynamic process where the role shifted from being primarily directive in the beginning to more enabling as change progressed and staff were encouraged to continue to drive the change process forward themselves. This parallels the findings of Harvey et al. (2002). Further, facilitation for EBP in nursing must also involve change management at multiple levels.
(Regan, 1998). Working with different disciplines and possessing respect and credibility within the setting are viewed as characteristics (Owen & Milburn, 2001) along with knowledge and skills in research methods and process (Winch et al., 2005). Facilitator characteristics and skills reflect the process with certain knowledge or training necessary for facilitation to occur (Wallin, Profetto-McGrath & Levers, 2005).

Facilitation and other roles. Facilitation may be associated with or a part of other roles. Advanced-practice nurses, clinical nurse specialists, and clinical nurse educators may have the skills and qualities required of facilitators and are well-positioned to assume the intermediary role (Ferguson et al., 2004). Data collected by Pepler et al. (2006) from a sample of nurses indicates specialists and educators are expected to manage research use, while primary nurses’ responsibility is seen as direct patient care. Even where managers perceived their role in research implementation as facilitating and providing support, the ultimate responsibility for research use was still seen to rest on individual practitioners (Caine & Kenrick, 1997). This is important to consider from a practical perspective when organizing an implementation endeavour.

Successful facilitation by clinical nurse educators is associated with positive attitudes regarding research use and increased use is noted by those with higher education (Milner et al., 2006). Opportunity to consult with clinical nurse specialists, expert nurse clinicians, or educators, is a significant predictor of research utilization (Estabrooks, Midodzi, Cummings & Wallin, 2007). Wallin, Profetto-McGrath, et al. (2005) point out that clinical nurse specialists and educators may have the appropriate knowledge and skills for facilitation but they also have numerous other responsibilities possibly taking priority. These more recent observations are important in terms of the different roles and functions and who actually assumes responsibility for the facilitation of EBP.
Facilitation has been recognized by Harvey et al. (2002) and others as a distinct role in itself. It is now emerging as potentially a part of other roles such as advanced-practice nurses, clinical nurse specialists, educators, and managers, creating some confusion. In addition, individuals influencing practice change, or change agents, and facilitators are referred to by different designations (e.g. facilitators, link nurses, opinion leaders, etc.) (Nagykaldi et al., 2005; Richens, Rycroft-Malone & Morrell, 2004). In their concept analysis, Harvey et al. sought to distinguish facilitation from other change agents and proposed facilitators may be differentiated by their association to the change setting and the strategies used to effect change. For instance, facilitators may be internal or external to the organization and use strategies which enhance organizational systems and culture, but the division between change agent roles is unclear. In a recent review, Thompson et al. (2006) examined different change agent concepts in health, education, and management literature. They noted that all roles operate under the premise that increasing access to knowledge leads to change and the differences observed stem from their underlying theoretical bases. Similar to Harvey et al.’s findings, facilitators utilize group dynamics to influence change and the role is boundary-spanning for a specified time period. A conclusion in Thompson et al.’s review was that confusion and overlap among the concepts still exists.

This review focused exclusively on facilitation and facilitators in nursing and it is noteworthy that the skills and attributes are consistent with the broader literature (see Harvey et al., 2002 & Thompson et al., 2006 for more detailed discussion of the differences among roles). It is becoming obvious that a wide range of skills and characteristics are essential for effective facilitation. Skills are learned and change over time through experience (Newton, 2003). Being flexible is an important asset (Owen & Milburn, 2001; Wallin, Rudberg, et al., 2005). As
proposed in Harvey and colleagues’ (2002) analysis, selecting skills applicable to specific situations is what may be needed for effective facilitation.

Effectiveness of Facilitation Interventions involving Nursing Practice

A number of studies evaluating facilitation in health care were included in Harvey et al.’s (2002) analysis but none appeared to focus on nursing. In the years following, we were not able to locate any randomized-controlled trials assessing the effectiveness of facilitation on changing nursing practice. Rather, we found several trials investigating the effectiveness of trained nurse facilitators in influencing changes in primary care general practitioners’ offices (Hogg et al., 2008; Hulscher et al., 1997; Lemelin, Hogg & Baskerville, 2001). These studies involved a number of staff, with nurses in some but not all practices, and as their focus was primarily on medical practice thus not included in this review.

Role Summary

To synthesize the review findings, a synoptic table was constructed which outlines the activities involved in facilitation of EBP in nursing and the skills and attributes required (see Figure 4). The information was organized in specific stages related to the process of carrying out an evidence implementation: planning for change, leading and managing change, monitoring progress and ongoing implementation, and evaluating change.
### Figure 4. Synoptic table of facilitation of EBP in nursing.

<table>
<thead>
<tr>
<th>1) Planning for change</th>
<th>2) Leading and managing change</th>
<th>3) Monitoring progress and ongoing implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increasing awareness</strong></td>
<td><strong>Knowledge and data management</strong></td>
<td><strong>Problem-solving</strong></td>
</tr>
<tr>
<td>1.1 Highlighting a need for practice change</td>
<td>2.1 Knowledge translation/dissemination (assisting with conducting literature searches, appraising and summarizing the evidence)</td>
<td>3.1 Problem-solving and addressing specific issues</td>
</tr>
<tr>
<td>1.2 Selecting an area for change relevant to staff/recognized as a priority</td>
<td>2.2 Helping to interpret the research and apply it in practice</td>
<td>3.2 Making changes to the developed plan as necessary</td>
</tr>
<tr>
<td>1.3 Stimulating critical inquiry and assisting groups to develop/refine specific clinical practice questions</td>
<td>2.3 Providing resources/tools for change</td>
<td>3.3 Networking</td>
</tr>
<tr>
<td>1.4 Assisting with/performing a formal/informal practice audit</td>
<td><strong>Project management</strong></td>
<td><strong>Providing support</strong></td>
</tr>
<tr>
<td>1.5 Interpreting baseline data and providing feedback/insight into performance gaps</td>
<td>2.4 Identifying a leader</td>
<td>3.4 Mentoring and role-modelling EBP</td>
</tr>
<tr>
<td>1.6 Emphasizing enhanced patient outcomes as opposed to poor practice as reason for change</td>
<td>2.5 Establishing and allocating roles/delegating responsibilities</td>
<td>3.5 Maintaining momentum and enthusiasm</td>
</tr>
<tr>
<td><strong>Developing a plan</strong></td>
<td>2.6 Advocating for resources and change</td>
<td>3.6 Acknowledging ideas and efforts</td>
</tr>
<tr>
<td>1.7 Assisting with development of an action plan</td>
<td><strong>Recognizing the importance of context</strong></td>
<td>3.7 Providing ongoing support/reassurance and constructive feedback</td>
</tr>
<tr>
<td>1.8 Helping identify and determine solutions to address potential barriers to EBP</td>
<td>2.7 Creating an open, supportive, and trusting environment conducive to change</td>
<td>3.8 Empowering group members</td>
</tr>
<tr>
<td>1.9 Goal-setting and consensus-building (shared-decision making)</td>
<td>2.8 Helping to build in the structures/processes to support staff and help them overcome obstacles</td>
<td>3.9 Providing advice</td>
</tr>
<tr>
<td><strong>Fostering team-building/group dynamics</strong></td>
<td>2.9 Creating local ownership of change</td>
<td><strong>Effective communication</strong></td>
</tr>
<tr>
<td>2.13 Relationship-building</td>
<td>2.10 Assisting with adapting evidence to the local context</td>
<td>3.10 Providing regular communication (emails, phone calls)</td>
</tr>
<tr>
<td>2.14 Encouraging effective teamwork</td>
<td>2.11 Boundary-spanning (addressing organizational systems/culture), managing the different requirements of each discipline/role</td>
<td>3.11 Keeping group members informed</td>
</tr>
<tr>
<td>2.15 Enabling individual and group development</td>
<td>2.12 Tailoring/adapting facilitation services to the local setting</td>
<td><strong>4) Evaluating change</strong></td>
</tr>
<tr>
<td>2.16 Encouraging/ensuring adequate participation</td>
<td><strong>Assessment</strong></td>
<td><strong>4.1 Performing/assisting with evaluation</strong></td>
</tr>
<tr>
<td>2.17 Increasing awareness of and helping overcome resistance to change</td>
<td><strong>4.2 Linking evidence implementation to patient outcomes</strong></td>
<td><strong>4.3 Acknowledging success, recognizing and celebrating achievements</strong></td>
</tr>
<tr>
<td>2.18 Consensus-building (shared decision-making)</td>
<td><strong>Administrative and project-specific support</strong></td>
<td></td>
</tr>
</tbody>
</table>
SKILLS AND ATTRIBUTES

Tact and sensitivity; political, negotiation, and conflict management skills; marketing skills; having vision; project planning skills; innovation and resourcefulness; keen and able to generate interest; positive and confident; ability to act as a catalyst for change; active listener; strategic thinker

knowledgeable and experienced; critical thinking and appraisal skills; knowledge of research methods and process and data analysis; motivating, enabling, and energetic; flexible and adaptive (knowing when to take over and complete tasks and when to assist and enable clinicians to complete the tasks themselves); leadership skills; project management skills; ability to secure and obtain adequate resources; reliable; authority/status and ability to influence change in practice; authentic and credible (locally and clinically); understanding of the local context as well as the larger organizational context (unit and organizational culture/infrastructure/vision/values); interpersonal and interaction skills; group management and team-building skills; computer/IT skills; organized; teaching skills

supportive, encouraging, and empathetic; problem-solving; persistence and patience; networking skills and appropriate contacts; consistent and available; committed and responsive; communication skills

non-judgmental; analytical skills
Discussion and Recommendations

We undertook this enquiry to describe how facilitation in nursing has evolved over the past decade. Many aspects of the groundbreaking work of the United Kingdom group (Kitson, Harvey, Rycroft-Malone and colleagues) remain relevant today. Facilitation continues to be applied in implementation studies without specific explanation of meaning, which makes it difficult to replicate either in research or practice. Definitions provided by Kitson et al. (1998) and Harvey et al. (2002) are frequently referenced, indicating they are relevant and resonate with those in the field and their experiences. Facilitation is still described as involving two major elements of ‘supporting’ and ‘enabling’ practitioners to improve practice through evidence implementation. Regarding facilitation, articles (n = 31/39) frequently referenced the conceptual framework originally developed by Kitson and colleagues and/or the concept analysis by Harvey et al. This may account for some of the consistency of the results in relation to the findings and ideas put forward in these germinal articles.

Since the publication of Harvey et al.’s analysis in 2002, there has been growing emphasis on relationship-building and communication (Stetler et al., 2006; Thompson et al., 2006). More evident are the strategies being employed to promote change. These activities range from providing task-oriented, practical assistance to enabling individuals and groups to change their ways of working, which is reflective of what Harvey et al. earlier described. The literature provides little new information on the skills and education of those undertaking facilitation. Training topics are outlined but not described in sufficient detail.

Over the past decade, new components or themes have emerged in the literature of how the concept of facilitation is being used, generating further discourse, specifically,
• facilitation is now being viewed as both an individual role as well as a process involving individuals and groups (e.g. it is not always a ‘facilitator’ filling the role; groups may engage in the process of facilitation);

• project management and leadership are emerging as aspects of facilitation (e.g. someone must be accountable and responsible for initiating and seeing the change process through) with facilitators actually assuming the project leadership role;

• no specific approaches appear superior, but tailoring facilitation to the local context is increasingly considered critical;

• there is growing emphasis on the importance of evaluation and linking outcomes to action (e.g. nurses observing positive outcomes as a result of implementing change).

Previously, facilitation was largely viewed as being achieved by a person carrying out a specific role. What is evident in recent literature is that facilitation is seen as both a specific role (e.g. facilitator) as well as a process (e.g. a team or group engaging in facilitation). From a practical perspective and at a program level, this invites consideration of the use of structures already in place that might serve as venues for the facilitation process such as nursing practice councils, staff meetings, quality circles, and unit councils. These could be used for facilitating EBP rather than starting a new group and thus reduce duplication of effort. Practically and strategically, these bodies often have evidence implementation included within their mandate and are responsible for advising and approving practice guidelines and changes in practice. In these entities, relationships among members are often established with consensus and decision-making processes already in place. Importantly, they have the influence and authority to effect changes in practice which have previously been identified as valuable (Kitson et al., 1998).

Facilitation may be a distinct role or potentially embedded as part of other roles such as advanced-practice nurses, clinical nurse specialists, educators, and managers. These nurses often
actively engage in facilitation as a major component of their role. However, it is more implicit than explicit and therefore not well-recognized. At a policy level, organizations are obliged to create environments where nurses can meet the standards and requirements designated by their regulatory bodies, which includes research utilization and EBP. Practice change in most settings is not entirely within an individual nurse’s decision-making realm and authority; thus, organizations need to consider their different nursing roles and identify who is going to facilitate these requirements. Lack of time and authority to change practice has long been recognized by practitioners as a barrier to evidence implementation (Funk, Tornquist & Champagne, 1995; Kajermo, Nordström, Krusebrant & Björvell, 1998; Parahoo & McCaughan, 2001). Facilitation function already may exist in roles and in making this recognized, the change process would be clearly led and managed. Acknowledging facilitation responsibilities within existing roles in settings and teams is a promising avenue to support EBP without adding new resources. Key to success may be deputizing and authorizing this function.

Organizations seeking to advance EBP need to identify how facilitation is going to happen, commit resources, and nominate someone responsible to manage the process to promote and maintain change. An individual or a team may assume responsibility for carrying out the day-to-day tasks (e.g. organizing paperwork and scheduling meetings) and addressing larger issues (e.g. advanced skills training in literature searching and appraisal) with organizational support of dedicated time and resourcing.

Conclusions

Facilitation continues to evolve as an important element in advancing evidence-based nursing practice. Literature in the last decade has translated the concept into a more practical and applied process. However, no randomized-controlled trials were identified investigating facilitation in effecting changes in nursing practice. There is a need for research on the
effectiveness of facilitation interventions in nursing as well as their cost-effectiveness. Further to Harvey et al.’s (2002) findings, questions of the sustainability of facilitation interventions remain unanswered. Nurses have identified that practice change would not be sustained without ongoing support (Ruston, 2002). As one group reported, there is “no natural substitute for the facilitator” (Wallin, Rudberg, et al., 2005, p. 69).

To further advance this area of EBP, we recommend several focused areas for future attention and research:

- *effectiveness* of facilitation on changing nursing practice with researchers providing explicit descriptions of the facilitation approach/intervention.
- *sustainability* of facilitation approaches and what structures and processes need to be in place to maintain practice change.
- relative importance of the different *combination of skills* required for effective facilitation.
- relationship between *contextual characteristics* and *components of facilitation interventions* used to better tailor facilitation to specific local settings.

This enquiry has uncovered evolving aspects of facilitation as both a role and process in the implementation of EBP in nursing. Facilitation itself should be considered a distinct intervention on one level and on another it involves organizing and implementing other change strategies. We offer insight into what facilitation entails in relation to nursing and a starting point for future avenues of research in the area. A significant gap exists in how facilitation is being used to make changes focused on nursing practice. Advancing nursing knowledge in the area could provide information for developing facilitation approaches which could be incorporated into tailored training programs and the continuing professional development of individuals whose role involves facilitation. A greater understanding of the experience of facilitation at the point-of-
nursing care would provide insight into the dimensions of the role and process as it relates to nursing. Facilitation may be an important and critical strategy in and of itself to bridge the gap between research and practice. To operationalize facilitation, a clear and more comprehensive understanding of what specifically facilitators are doing to enable changes in nursing practice is needed. This will lay the groundwork for the design of practical strategies for EBP in nursing where facilitation is a key element and allow for rigorous evaluations of its effectiveness.
References


Sipilä, R., Ketola, E., Tala, T., & Kumpusalo, E. (2008). Facilitating as a guidelines implementation tool to target resources for high risk patients - the Helsinki Prevention Programme (HPP). *Journal of Interprofessional Care, 22*(1), 31-44.


CHAPTER THREE

Conceptual Framework Development

This chapter will describe the development of a provisional conceptual framework of facilitation of evidence-based nursing practice. Following completion of the focused literature review presented in Chapter 2, analysis and reflection were undertaken to organize the findings into a framework. The literature-based conceptualization of facilitation is described and the initial iteration of the framework is presented. The intended use of the framework was to guide the next phase of the research and inform the methodology for examining the actual, active facilitation occurring in a natural experiment. Using the provisional framework, an audit tool was developed and is presented to conclude the chapter. The tool and framework represent a synopsis of the current literature and understanding of the concept.

Conceptual frameworks convey ways of thinking about a problem or of showing how complex things work (Bordage, 2009). Frameworks present important variables and outcomes and how they relate to one another (Bordage). A conceptual framework related to facilitation can help practitioners begin to reflect on the process and the underlying factors involved. The overarching aim of the thesis research is to describe facilitation as a role and process in the implementation of evidence-based practice (EBP) in nursing. I sought to determine a way of representing the multifaceted nature of facilitation and to conceptualize it in a meaningful and useful way for practitioners to hopefully enhance efforts to implement evidence into practice. The objective was to develop and refine a conceptual framework demonstrating the practical aspects of facilitation in moving evidence into nursing practice. First, I aimed to develop a provisional framework drawing from the theoretical and empirical literature on how the concept is being researched, studied, and theorized, which will be outlined in this chapter. Second, I intended to elucidate the actual, active experience of facilitation of EBP in nursing (Chapter 4). Finally, I planned to integrate these
various perspectives to gain a more comprehensive view of the concept and refine the initial conceptualization of facilitation (Chapter 5). The framework resulting from the research is intended to guide practitioners and organizations in planning for change through the use of evidence.

Method

I conducted the focused review of the literature on facilitation of EBP in nursing to identify the definitions of the concept, the strategies involved, the characteristics and skills of facilitators, and the effectiveness of facilitation interventions (Chapter 2). The results of the review were used to develop the initial iteration of the framework. As outlined in the previous chapter, I examined published theory and research-based papers to identify the scope and breadth of facilitation activity as described in the literature and the necessary skills and attributes of facilitators or individuals engaged in facilitating EBP in nursing. Facilitation is described as “a valuable and critical process of interactive problem-solving and support, which occurs in the context of a recognized need for improvement and a supportive interpersonal relationship” (Stetler et al., 2006, Findings section, para. 7). Following a simple content analysis on the final set of 39 papers, the specific activities and critical attributes involved in facilitation were evident. Commonalities were discovered across papers and project management and leadership emerged as noteworthy aspects (Dogherty, Harrison & Graham, 2009, under review).

I grouped the individual and combined elements of facilitation emphasized and apparent in the literature into four, overarching stages. Each of the stages contains associated activities depending on the purpose or phase of facilitation or implementation:

1 – Planning for change
2 – Leading and managing change
3 – Monitoring progress and ongoing implementation

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4 – Evaluating change

Each stage includes a number of groupings of activities into which the information was synthesized, highlighting the unique, practical aspects as well as the skills of facilitation of EBP in nursing (see Figure 4). In general, upon increasing practitioners’ awareness of a need for change and developing an action plan, a variety of change strategies are utilized to facilitate evidence uptake depending on the context where change is to take place. Facilitation may involve a number of activities from planning meetings and providing resources to empowering individuals. Additionally, a considerable number of skills are described in the literature from project planning to motivational and enabling skills. The process is iterative and occurs over a period of time with ongoing monitoring and support provided in progressing toward change. This synthesis of the literature was used as the basis for development of the initial iteration of the conceptual framework.

Conceptualization of Facilitation of EBP in Nursing

I designed the framework to convey the broad, overarching nature of facilitation as a process of moving evidence into nursing practice and to identify the fundamental critical elements at each stage of the process that are commonly articulated in the literature. In developing the initial framework to enhance understanding of the concept, several questions were considered:

1) What is critical about facilitation as a role and process in the implementation of EBP in nursing? What must practitioners or organizations need to know or have in place to engage in facilitation?

2) Does facilitation follow a linear timeline or is there temporal overlap among elements or constructs?

3) What is the nature of the relationship between elements of facilitation and related constructs? How are these relationships best illustrated?
Answers to these questions and further discourse and consultation with the thesis committee surrounding the concept helped generate the formulation of ideas resulting in the initial conceptualization of facilitation. Several versions were circulated amongst the committee with feedback provided and incorporated to develop the provisional framework, which in turn drove the remainder of the thesis research. The focused review underscored the importance of the local context as a key element which required consideration and inclusion in the framework (Dogherty et al., 2009, under review). In general, the facilitation approach taken depends on the characteristics and needs of the local setting where change is to take place. After identifying the key components and structure of facilitation, the next step was to arrange these elements into an organized set of ideas and relationships.

The framework articulates the process of facilitation as a means of moving evidence into nursing practice and is illustrated in Figure 5. Facilitation is viewed as taking place within a certain context or setting and in this way, is situated in the larger grey circle denoting context and its associated elements. Evidence suggests that contextual characteristics may affect the process (Pepler et al., 2005, 2006) and working with practitioners to tailor and adapt facilitation services and clinical practice guidelines to a local practice setting is mentioned in the literature (Ellis, Howard, Larson & Robertson, 2005; Jones et al., 1996). Based on the results of the review, facilitation appears multifaceted and encapsulates a multitude of activities throughout the change process as indicated in the square boxes (Dogherty et al., 2009, under review). There is a timing factor present in that the process begins with planning for change where there must be recognition of a problem or need for change and development of an action plan with specific goals and objectives. Subsequently, facilitation involves leading and managing change through the employment of a number of activities and continuing to provide support throughout ongoing implementation. Another important element is evaluation and feedback and the importance of
practitioners recognizing the results of their efforts, particularly in improved patient outcomes (Dogherty et al.). It should be noted that the boxes are connected by double arrows indicating that the process is not linear but iterative in nature. For example, groups may have to revisit the action plan and make adjustments throughout the change process as barriers and facilitators to implementation are encountered. The assumption is that individuals or groups go back and forth between the stages throughout the implementation and facilitation process. Necessary skills and attributes were not incorporated into the framework at this point as discussions on integration of this information were ongoing.
Figure 5. Facilitation in evidence-based practice in nursing – Provisional framework (initial iteration).
Use of the Framework to Guide the Research

The provisional framework and synoptic table outlining facilitation in EBP in nursing were used to guide the next phase of the thesis research. I formulated the information into an audit tool to examine and analyze data for examples of the facilitation activity occurring in a natural experiment of active early adaptation and implementation of practice guidelines. The Canadian Partnership Against Cancer [http://www.partnershipagainstcancer.ca], also known as the Partnership, is a Pan-Canadian initiative supporting knowledge translation activity for improved care through guideline use (Canadian Partnership Against Cancer Corporation, n.d.). Various groups in cancer care were facilitated to adapt guidelines and plan for implementation. Case-study data containing documentation from these groups were accessed and classified utilizing the audit tool. The tool specified various facilitation activities against which the data extracted from the case audit could then be evaluated (see Appendix A). The next phase of the research is described in the following chapter. The initial framework outlines facilitation as described in the literature whereas the next phase of work sought to describe what facilitation entails in action and how it was being used in a ‘real-world,’ practice setting to influence change.

Conclusion

The provisional framework and focused review of the literature provide a substantial understanding of facilitation of EBP in nursing and form the basis for beginning to look at the process and role in action. The framework attempts to illustrate the relationships among important elements of facilitation and therefore has the potential to advance knowledge by guiding exploration into the meaning and importance of these elements and their related constructs. The purpose of the next steps of the research was to explore which activities or characteristics are present in active facilitation and whether the literature-based conceptualization is complete by tracking the activities of people actively facilitating EBP in nursing. Finally, following the next
phase of enquiry (Chapter 4), the provisional framework was modified to incorporate both the theoretical and experiential perspectives to outline the role and skills of facilitation of EBP in nursing. This new conceptualization may help practitioners reflect on the role and process in a more meaningful way and guide those seeking to facilitate evidence uptake within their local context.
References


CHAPTER FOUR

A mixed-methods study of the role and process of facilitation in a natural experiment of guideline adaptation and early implementation

[Prepared for submission to Implementation Science]

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Abstract

Background: Facilitation is emerging as an important component in the uptake of evidence in clinical practice. However, it is unclear from a practical perspective how facilitators move evidence into nursing practice.

The Canadian Partnership Against Cancer, also known as the Partnership, is a Pan-Canadian initiative supporting knowledge translation activity for improved care through guideline use. Facilitators assisted various cases to begin the process of evidence implementation by adapting a guideline and planning for implementation.

Methods: To gain a more comprehensive understanding of the nature of facilitation, we conducted a descriptive, mixed-methods evaluation. Specifically, we examined the role and skills of individuals actively engaged in facilitation and the actual facilitation activities occurring within the Partnership. An audit tool outlining 46 discrete facilitation activities was developed based on the results of a focused literature review. The tool was used to examine the facilitation activities noted in the case documents (emails, meeting minutes, field notes, etc.) of 3 nursing-related cases in the Partnership study. Six facilitators also participated in a semi-structured focus group interview to further examine the concept of facilitation based on their practical experiences. The case-audit data were analyzed through a simple, focused content analysis and triangulated with participant responses from the focus group interview.

Results: The 46 discrete, practical activities discovered in the literature were in large part found as occurring within the 3 cases. An additional 5 new, distinct activities related to facilitation were found in the case documentation. Case members also performed certain facilitation activities in conjunction with or in addition to appointed facilitators.
Conclusions: Findings suggest that facilitation is a multifaceted process and a team effort.

Communication and relationship-building are key elements. The practical aspects of facilitation explicated in this study validate what has been previously noted in the literature and expand what is known about facilitation. With a better understanding of what facilitation entails, future research should concentrate on evaluating the effectiveness of facilitation interventions in influencing changes in nursing practice.
Background

Integration of evidence into practice remains a poorly understood, complex process. There is a gap in health care between what is known and what is done (Davis et al., 2003). Failure to incorporate the latest scientific evidence into practice results in inappropriate or overuse of ineffective treatments as well as underuse of proven effective treatments (Berwick, 2003). This is unsafe for patients and suboptimal use of health-care resources. Consequently, research into changing practice to reflect best available evidence has become an important health services and practice area of enquiry. There has been increasing interest in the design and evaluation of ways to enhance evidence implementation and research utilization in health care.

Facilitation is emerging as a method for encouraging evidence uptake in clinical practice across health-care disciplines and particularly in nursing. Published in 1998, Kitson, Harvey, and McCormack developed a conceptual framework proposing that successful implementation is dependant on the relationship between three key factors: the nature and level of the evidence, the quality of the context, and facilitation. The framework developers’ experience suggests that facilitators play an important role in assisting individuals and teams with identifying what needs to change and how to make these changes to incorporate evidence into practice (Rycroft-Malone et al., 2002).

In further developing the framework, Harvey et al. (2002) conducted a concept analysis of facilitation across a range of health-care literature published between 1985 and 1998. Their findings support that facilitation involves helping others to change practice with the purpose of facilitation “ranging from a discrete task-focused activity to a more holistic process of enabling individuals, teams and organizations to change” (Harvey et al., p. 578). At issue are the limited descriptions and lack of rigorous evaluations of the concept. In summary, Harvey et al. concluded
that the concept of facilitation is partially developed and further research is needed to describe and illustrate how it relates to evidence implementation.

To understand how the nature of facilitation has evolved over the last decade, especially given rapid advancements in the field of implementation science, we conducted a focused literature review (Dogherty, Harrison & Graham, 2009, under review). Recognizing that what is actually involved in facilitation is poorly understood from a front-line nursing perspective, we chose to focus on the practical elements of the concept (e.g. what facilitation of evidence uptake entails in nursing practice). Facilitation continues to be described as supporting and enabling practitioners to improve practice through evidence implementation. There is growing emphasis on relationship-building and communication as part of the role (Stetler et al., 2006; Thompson, Estabrooks & Degner, 2006). In line with Harvey et al.’s (2002) findings, we found that facilitation ranges from providing task-oriented, practical assistance to enabling individuals and groups to change their ways of thinking and working.

Over the past decade, new components or themes have emerged in conceptualizations of facilitation in knowledge uptake, specifically,

- facilitation is viewed as both an individual role as well as a process involving individuals and groups (e.g. it is not always simply a ‘facilitator’ filling the role; groups or teams may engage in the process of facilitation);
- project management and leadership are emerging as aspects of facilitation (e.g. someone must be accountable and responsible for initiating and seeing the change process through) with facilitators actually assuming the project leadership role;
- no specific approaches appear superior but adapting and tailoring facilitation to the local context is increasingly considered critical;
there is growing emphasis on the importance of evaluation and linking outcomes to action (e.g. nurses observing positive outcomes as a result of implementing change) (Dogherty et al., 2009, under review).

Recent literature has translated the concept into a more practical and applied process but a significant gap exists in how facilitation is being used to make changes in nursing practice. Thus, there is a need for clear descriptions of facilitation interventions and the structures and elements involved when moving evidence into nursing practice. Facilitation could be considered a distinct intervention; however, there is a need for studies defining and specifically examining facilitation to understand its contribution to successful implementation across various types of projects and contexts (Stetler et al., 2006). To operationalize facilitation, a clear and more comprehensive understanding of what specifically facilitators are doing in real situations to enable changes in nursing practice is needed. This will lay the groundwork for the design and delivery of practical strategies for EBP where facilitation is a key element and allow for rigorous evaluations of its effectiveness.

The Partnership Study

This research was carried out alongside a larger, natural experiment case-series study. The Canadian Partnership Against Cancer [http://www.partnershipagainstcancer.ca], also known as the Partnership, is a Pan-Canadian initiative supporting knowledge translation activity for improved care through guideline use (Canadian Partnership Against Cancer Corporation, n.d.). In this larger, case-series study, 5 self-identified cases volunteered to use a systematic methodology [http://www.adapte.org] (Adapte, 2007) to adapt existing clinical practice guidelines for Canadian use and begin planning for implementation. The larger study’s focus was on the adaptation methodology and how cases proceeded through the guideline adaptation process. An in-depth process evaluation followed their course in selecting, adapting, and beginning to plan for
implementation of these guidelines. Detailed accounts of this process were documented for each case. Thus, the larger study provided the context for studying facilitation in the initial phases of an evidence implementation.

Each of the 5 cases had a dedicated local facilitator (n = 5) and there were two external facilitators who provided assistance to all of the cases (n = 2). Local and external facilitators were appointed to assist the cases, or groups, in cancer care to begin an evidence implementation by adapting a guideline and planning for implementation. Local facilitators were ‘in the field’ facilitating cases and in close contact with case members. External facilitators were university-based and off-site providing strategic and methodological support. As well, each case had an appointed lead and/or co-leads for their respective projects and these individuals would be considered opinion leaders and/or champions in their field.

Study Conceptualization

Based on the findings of the focused literature review, we have conceptualized facilitation as a multifaceted process involving a number of different activities. A synoptic table was created outlining the major elements of facilitation of EBP in nursing (Dogherty et al., 2009, under review). This synthesis demonstrates the practical aspects of facilitation in moving evidence into nursing practice and the associated activities involved. It represents the current understanding of the concept of facilitation from the literature.

Purpose and Objectives of the Study

The overall aim of this study was to gain a more comprehensive understanding of the activities and skills of individuals actively engaged in facilitation and to describe the process of facilitation occurring within the Partnership study. The following questions guided the enquiry:

1) What activities were performed by appointed facilitators in the Partnership study?
2) Does the evidence and theory in the literature encompass the activities undertaken by these facilitators?

3) Were there facilitation activities performed by those other than the appointed facilitators?

4) What are the facilitators’ perceptions of the most important elements of facilitation based on their practical experiences?

5) What do facilitators themselves identify as the skills and knowledge required for effective facilitation?

Methods

A descriptive, mixed-methods design using case audit and focus group methodologies was chosen to examine the nature of facilitation occurring within the Partnership study. These methods allowed for an in-depth investigation of the concept of facilitation, specifically from the detailed overall process tracking undertaken by the cases and followed by the Partnership study research team.

Participants and Sites

To study a range of experience and contexts, 3 cases were purposefully selected from the Partnership study. I sought a sample representing different areas of nursing practice and different levels of guideline implementation (e.g. local, regional, etc.). In keeping with the thesis focus on facilitation of EBP in nursing, the cases were chosen because the plan was for implementation of guidelines designed for front-line nurses. Also, these cases represented a range in clinical guideline focus (assessment and management recommendations) and variation in the scope of implementation from a single setting to multiple settings. However, all had a goal to improve a certain aspect of cancer care (see Table 4). Each case had a dedicated local facilitator and access to external facilitation for process and methodology support as needed.
Table 4

**Partnership study case descriptions**

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<tr>
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<tbody>
<tr>
<td><strong>Scope of Implementation</strong></td>
<td>Pan-Canadian</td>
<td>Local</td>
<td>Regional</td>
</tr>
<tr>
<td><strong>Clinical Practice Guideline Focus</strong></td>
<td>Point-of-care, supportive symptom management for patients receiving chemotherapy, radiation, or palliative care</td>
<td>Best practices for local wound care in breast cancer patients following radiotherapy</td>
<td>Distress management in adult cancer patients across the continuum of care</td>
</tr>
<tr>
<td><strong>Target Guideline Users</strong></td>
<td>Front-line telephone triage nurses</td>
<td>Front-line nurses/radiotherapy technicians</td>
<td>Front-line care providers</td>
</tr>
</tbody>
</table>

Selected facilitators (4 local, 2 external) involved in the Partnership study were recruited for the focus group interview through a formal letter of invitation outlining the nature and purpose of the research. All 6 facilitators agreed to participate and written consent was obtained (see Appendix B). Participants were all actively involved in explicit facilitative activities and supported cases through the guideline adaptation and implementation process. These individuals came from various backgrounds including project management, research and data management, teaching, and nursing and all were female. Facilitators were designated to the role and not given any guidelines or training. Therefore, facilitation was operationalized on an individual basis.

**Data Collection**

Data collection focused on documenting the process and activities involved in facilitation and determining the key elements of the concept. We undertook two stages of data collection: case audit and focus group interview. Case-audit data were obtained from individual case manuals of the 3 facilitated Partnership cases. Each manual contained: detailed background information; case documents; email correspondence amongst case members; minutes and field notes of case
meetings; a detailed case log (indicating date, activity, who was involved, and a brief summary); a case liaison (indicating date and activity of external facilitator contact with the case); and a process timeline which mapped case progress through the guideline adaptation phases. The synoptic table prepared from the results of the literature review (Dogherty et al., 2009, under review) was used to formulate an audit tool and guided data collection to examine and analyze case-series data for examples of the facilitation activity occurring in the Partnership study. The tool specified activities and actions related to facilitation against which the data extracted from the case audit could then be evaluated (see Appendix A).

In order to avoid predetermining results based on the facilitation literature, a multi-step approach was used to collect data from the individual case manuals.

1. One author (EJD) examined all of the documentation for each individual case to determine the activities performed by appointed facilitators and created an exhaustive list of these activities and corresponding examples per case. The general definition of facilitation put forth by Stetler and colleagues (2006) broadly guided what was considered facilitation activity. They describe facilitation as “a deliberate and valued process of interactive problem solving and support that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship” (para. 4).

2. All of the case data were examined a second time using the theoretically-driven audit tool searching for examples of the facilitation activities previously noted in the literature. Activities that did not fit into these predetermined categories were kept separate for later inclusion once it was decided where they fit into the overall synoptic table.

3. Finally, EJD examined the original list of activities and examples from the first run-through of the data to determine their fit with the audit tool and categorized them accordingly. EJD checked to see if where these activities were inserted in the grid matched with where they
were categorized during the second round of data collection using the audit tool. Differences were noted. Again, activities that did not fit were kept separate for later categorization.

The combined data resulted in three complete data sets, one for each individual case. It should be noted that the case data were examined in an open-ended manner first to attempt to avoid forcing the placement of evidence or activities found into the predetermined categories outlined in the audit tool. For the purposes of this study, the intent was to capture facilitation activity regardless of who performed it. In this way, it was also noted whether the activities outlined in the audit tool were performed by individuals other than the assigned Partnership study facilitators.

Following completion of the case audit, a 50-minute focus group interview was conducted with facilitators (n = 6) as part of a monthly teleconference. The interview was structured upon gathering the participants’ perspectives on the following three key areas:

- Thoughts on the nature of facilitation and perceptions of the most important elements,
- Feedback and perspectives on whether the key elements of facilitation identified in the literature review and case audit reflected their experiences and if there was anything misrepresented or missing, and
- The skills and knowledge required for effective facilitation.

The focus group interview was used to confirm and modify the understanding and characteristics of facilitation identified in the literature review and case audit. Discussion topics and questions were circulated to participants prior to the session. EJD conducted the interview and took notes during the call. The session was audio-recorded and transcribed verbatim. Participant responses to the three general topic areas assisted in generating discussion and further exploration of facilitation amongst the group.
Data Analysis

Following the case audit, the data manager of the larger Partnership study, familiar with all 3 cases, checked the data sets to confirm that the evidence supported the different categories of facilitation as outlined in the audit tool. Subsequently, EJD and the data manager met to challenge interpretations and discuss any disagreements in order to reclassify the activities where necessary and to decide where the newly identified elements or actions fit into the overall synoptic table. The categories were reorganized and adjusted based on this discussion. Detailed notes were kept of all decisions made during this process and changes were tracked. During the audit, one author (EJD) kept field notes and a reflective journal of thoughts, questions, and ideas that arose regarding the data, categories, and interpretations of the data. These reflections were also brought forward to the data manager for comment and feedback.

To enhance credibility, the focus group interview served as a member check. A synthesis of the case-audit results was presented to participants. The case data were derived from documentation of participants’ communications and meeting notes. Their perceptions of the accuracy of these findings were sought in the focus group interview. Method triangulation enhanced credibility as multiple methods were used to address the research questions.

The case-series data were analyzed through a simple, focused content analysis. EJD examined the data to determine if each facilitation activity presented itself in the case documentation, by whom it was performed, and the recipient of the action. Additional information and examples of activities were formulated into new or existing categories. This information was synthesized and compared across cases to gain an overall description of facilitation and identify any unique, additional elements.

For each case, categories of facilitation were formulated into a table to determine whether examples of the facilitation activity were performed. This information was sorted into the type of
facilitation, which was colour-coded based on who was performing the facilitation action (e.g. green = local facilitator, red = external facilitator, etc.) (see Appendix C). The colour-coded tables enabled us to examine commonalities and differences in the data (e.g. in two cases, external facilitators performed an action whereas in the other case it was the local facilitator). Elements or activities that did not appear in the audit data were further explored in the facilitator focus group interview. Interview data were transcribed and participant responses analyzed based on the predetermined topic areas to identify similarities and differences in facilitators’ perceptions and experiences.

Ethical Approval

Ethical approval was received from the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board for the larger Partnership Guideline Adaptation Evaluation Study, led by MBH (#NURS-211-07). The facilitation study received separate approval from the same board (#NURS-226-08, see Appendix D). Supplementary approval and permission to access the case-series data collected as part of the larger Partnership project was obtained from the principal investigator (see Appendix E).

Results

This study examined the facilitation activity occurring in 3 cases adapting guidelines for use by front-line nurses and planning for implementation. Each case had a different clinical guideline focus and scope and level of implementation. One case focused on remote oncology supportive symptom management and was a Pan-Canadian group preparing a national guideline. The second case examined wound care following radiotherapy in breast cancer patients and planned for implementation at the local level. The third case chose to prepare a guideline for distress management in adult cancer patients and their scope of implementation was at the
regional level. Each case had a dedicated local facilitator and access to external facilitation as requested.

Study results are presented and structured in terms of the major findings related to the research questions. In considering the results, it is important to note some general similarities and differences between cases. All cases exhibited varying levels of facilitation activity and particularly intensive facilitation was provided by the local facilitators. However, two of the cases were more similar than the first. The dissimilar case had substantially more direct external facilitation support as well as more facilitation activities being performed by members of the case themselves. In all cases, but particularly in the dissimilar case, members of the case performed facilitation activities in conjunction with or in addition to the local and external facilitators.

Activities performed by appointed facilitators

An extensive listing of facilitation activities was evident in the case-series data as being performed by appointed facilitators in the Partnership study (see Table 5). In summary, 4 major stages of facilitation were identified and within those, 11 groupings of activity with 51 activities noted overall. Evidence of function related to local and/or external facilitation was found for almost all of these activities in at least one case but more often in multiple cases. However, there were a few exceptions as noted in Table 5. Activities performed by local facilitators and external facilitators in all of the cases are listed in Table 6.
### Facilitation processes and activities in the Partnership study

#### Planning for change

<table>
<thead>
<tr>
<th>Increasing awareness</th>
<th>Developing a plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Highlighting a need for practice change</td>
<td>7) Goal-setting and assisting with development of an action plan</td>
</tr>
<tr>
<td>2) Selecting an area for change relevant to staff/recognized as a priority</td>
<td>8) Helping identify and determine solutions to address potential barriers</td>
</tr>
<tr>
<td>3) Stimulating critical inquiry and assisting groups to develop/refine specific clinical practice questions</td>
<td>9) Displaying and generating enthusiasm at the start of the EBP</td>
</tr>
<tr>
<td>4) Assisting with/performing a formal/informal practice audit</td>
<td>10) Thinking ahead in the process</td>
</tr>
<tr>
<td>5) Interpreting baseline data and providing feedback/insight into performance gaps</td>
<td></td>
</tr>
<tr>
<td>6) Emphasizing enhanced patient outcomes as opposed to poor practice as reason for change</td>
<td></td>
</tr>
</tbody>
</table>

#### Leading and managing change

<table>
<thead>
<tr>
<th>Knowledge and data management</th>
</tr>
</thead>
<tbody>
<tr>
<td>11) Knowledge translation/dissemination (assisting with conducting literature searches, obtaining articles, appraising and summarizing the evidence)</td>
</tr>
<tr>
<td>12) Helping to interpret the research and apply it in practice</td>
</tr>
<tr>
<td>13) Providing resources/tools for change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recognizing the importance of context</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) Creating an open, supportive, and trusting environment conducive to change</td>
</tr>
<tr>
<td>18) Helping to build in the structures/processes to support staff and help them overcome obstacles</td>
</tr>
<tr>
<td>19) Creating local ownership of change</td>
</tr>
<tr>
<td>20) Assisting with adapting evidence to the local context</td>
</tr>
<tr>
<td>21) Boundary-spanning (addressing organizational systems/culture), managing the different requirements of each discipline/role</td>
</tr>
<tr>
<td>22) Tailoring/adapting facilitation services to the local setting</td>
</tr>
<tr>
<td>23) Relationship-building</td>
</tr>
<tr>
<td>24) Encouraging effective teamwork</td>
</tr>
<tr>
<td>25) Enabling individual and group development</td>
</tr>
<tr>
<td>26) Encouraging/ensuring adequate participation</td>
</tr>
<tr>
<td>27) Increasing awareness of and helping overcome resistance to change</td>
</tr>
<tr>
<td>28) Consensus-building (shared decision-making)</td>
</tr>
</tbody>
</table>
Table 5 (continued).

**Administrative and project-specific support**

| 29) Organizing/scheduling meetings | 32) General planning |
| 30) Leading/participating in meetings | 33) Providing skills training |
| 31) Gathering information and assembling/distributing reports and materials | 34) Taking on specific tasks |

| **Problem-solving** | **Providing support** |
| 35) Problem-solving and addressing specific issues | 38) Mentoring and role-modelling EBP |
| 36) Making changes to the developed plan as necessary | 39) Maintaining momentum and enthusiasm |
| 37) Networking | 40) Acknowledging ideas and efforts |
| 41) Providing ongoing support/reassurance and constructive feedback | 42) Empowering group members |
| 43) Providing advice/guidance/assistance | 44) Being available as needed |
| 45) Ensuring group remains on task and things are not missed (process/methodology is followed) |

| **Effective communication** | **Evaluating change** |
| 46) Providing regular communication (emails, phone calls) | 49) Performing/assisting with evaluation |
| 47) Keeping group members informed | 50) Linking evidence implementation to patient outcomes |
| 48) Acting as a liaison | 51) Acknowledging success, recognizing and celebrating achievements |

Activities not noted to be performed by appointed facilitators in the Partnership case-series data
Table 6

*Facilitation activities performed by both local and external facilitators across all 3 cases*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Local Facilitators</th>
<th>External Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing resources/tools for change</td>
<td>3/3</td>
<td>6/8</td>
</tr>
<tr>
<td>Tailoring/adapting facilitation services to the local setting</td>
<td>4/6</td>
<td>2/3</td>
</tr>
<tr>
<td>Consensus-building (shared decision-making)</td>
<td>2/3</td>
<td>2/3</td>
</tr>
<tr>
<td>Organizing/scheduling meetings</td>
<td>2/3</td>
<td>2/3</td>
</tr>
<tr>
<td>Leading/participating in meetings</td>
<td>3/6</td>
<td>3/6</td>
</tr>
<tr>
<td>Problem-solving and addressing specific issues</td>
<td>3/6</td>
<td>6/8</td>
</tr>
<tr>
<td>Providing ongoing support/reassurance and constructive feedback</td>
<td>2/3</td>
<td>3/6</td>
</tr>
<tr>
<td>Ensuring group remains on task and things are not missed (process/methodology is followed)</td>
<td>3/6</td>
<td>6/8</td>
</tr>
<tr>
<td>Providing regular communication (emails, phone calls)</td>
<td>2/3</td>
<td>2/3</td>
</tr>
</tbody>
</table>

Across all 3 cases, certain activities tended to cluster around local and/or external facilitators. For instance, local facilitators performed 3/3 of the activities under ‘effective communication’ in all of the cases in addition to 4/6 under ‘administrative and project-specific support,’ 2/3 under ‘knowledge and data management,’ 2/3 under ‘problem-solving,’ 3/6 under ‘recognizing the importance of context,’ and 3/6 under ‘fostering team-building/group dynamics.’ External facilitators performed 6/8 of the activities under ‘providing support’ in all of the cases and 2/3 under ‘effective communication.’

In mapping who was assisting whom, it was noted that local facilitators generally assisted members involved in each of the cases. Aside from the dissimilar case, external facilitators generally provided support and assistance to local facilitators who in turn assisted the case.
**Congruence with facilitation as described in the literature**

The results of the literature review were used to develop the initial synoptic table of facilitation activities, which was formulated into the audit tool. In analyzing the case-audit data, the literature synopsis encompassed most of the activities of the appointed facilitators but missing and additional activities were also noted. Four facilitation elements in the literature were not found as being performed by facilitators in these cases. Furthermore, five unique, additional aspects of facilitation were noted as part of the appointed facilitator role (see Table 7).

Table 7

**Missing and new elements of facilitation in relation to facilitation as described in the literature**

<table>
<thead>
<tr>
<th>Activities for which no documented evidence was found in the case-audit data of being performed by appointed facilitators</th>
<th>New activities identified as performed by appointed facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreting baseline data and providing feedback/insight into performance gaps</td>
<td>Displaying and generating enthusiasm at the start of the project</td>
</tr>
<tr>
<td>Creating an open, supportive, and trusting environment conducive to change</td>
<td>Thinking ahead in the process</td>
</tr>
<tr>
<td>Linking evidence implementation to patient outcomes</td>
<td>Taking on specific tasks</td>
</tr>
<tr>
<td>Acknowledging success, recognizing and celebrating achievements</td>
<td>Being available as needed</td>
</tr>
<tr>
<td>Ensuring group remains on task and things are not missed (process/methodology is followed)</td>
<td></td>
</tr>
</tbody>
</table>

There was no overall theme discovered in what was found in this study and not previously reflected in the literature but the new activities were associated with the supportive aspect of the role. In particular, being available as needed to the case and ensuring they remained on task were primarily supportive elements. All of the larger 11 groupings of activity and corresponding 4 stages of facilitation articulated in the foundational synopsis were able to capture both the existing and newly identified activities of facilitation.
Facilitation – a process beyond an assigned role

Certain facilitation activities were performed by case participants in conjunction with or in addition to the local and external facilitators. For instance, members of all 3 cases had a substantial role in identifying a leader for their particular projects. Other areas where in the majority of cases the activities were performed by case members, as opposed to facilitators, included: highlighting a need for practice change, selecting an area relevant to staff/recognized as a priority, performing a practice audit, helping to interpret the research and applying it in practice.

On the other hand, there were certain areas where cases required substantial facilitation from both external and local facilitators and where none of the facilitation activities were performed by case participants themselves. These areas included: providing resources/tools for change, tailoring/adapting facilitation services to the local setting, consensus-building, problem-solving, and providing ongoing support/reassurance. Other areas where the majority of activities were performed by external and local facilitators in most but not all cases were: enabling individual and group development, increasing awareness of and helping overcome resistance to change, providing skills training, making changes to the developed plan, and acting as a liaison.

Key elements of facilitation as perceived by facilitators

As part of the focus group interview, facilitators were asked about their perceptions of the most important elements of facilitation based on their practical experiences. In reviewing the synopsis of facilitation activities discovered in the case audit (see Table 5), participants’ comments were very positive and the items appeared to have face validity. They were able to relate to these activities as they fit with their experiences and participants commented that the layout made sense. As one local facilitator stated, “Because all these tasks listed here I could, I can relate to like oh yeah, I do that, I do that, oh yeah.”
Of the 11 major groupings of activities, 3 were perceived by participants as central tenets of facilitation: knowledge and data management, project management, and administrative and project-specific support. The administrative piece was seen as an especially important part of the facilitator role because individuals involved in these projects have numerous other responsibilities and priorities. As a result, “...the project lead and the chair don’t have time to try and find proper times for teleconferences and to share information.” The administrative and follow-up support was perceived as a key factor in driving the projects forward. Several specific activities also emerged as central to the role (see Table 8).
Table 8

Key facilitation activities identified by facilitators

<table>
<thead>
<tr>
<th>Activity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasizing enhanced patient outcomes (as opposed to poor practice as reason for change)</td>
<td>“...you’ve got to have the right person with the right knowledge.”; “...you really have to pick the right leader otherwise you could spend a lot of time and develop a guideline that just wouldn’t be all that useful.”; someone who has “charisma” and “street credibility”</td>
</tr>
<tr>
<td>Identifying a “qualified” leader</td>
<td>“...you’ve got to have the right person with the right knowledge.”; “...you really have to pick the right leader otherwise you could spend a lot of time and develop a guideline that just wouldn’t be all that useful.”; someone who has “charisma” and “street credibility”</td>
</tr>
<tr>
<td>Increasing awareness of and helping overcome resistance to change</td>
<td>“They don’t want to go there because maybe they’re afraid a bit about guidelines. And what they really are and you know, who’s going to be using them and who’s going to be writing them, et cetera. To you know, by trying to be positive and supportive and inclusive, gee people are buying in and saying “this is fantastic, this is great.”</td>
</tr>
<tr>
<td>Gathering information and assembling/distributing reports and materials</td>
<td>“...making sure people got all the appropriate materials.”; “...one of the most important things is just getting the information out to the group...”</td>
</tr>
<tr>
<td>Networking</td>
<td>“...making sure you have people that you can call if there are issues.”</td>
</tr>
<tr>
<td>Maintaining momentum and enthusiasm (“cheerleader”)</td>
<td>“...the coaching and the keeping people motivated and kind of carrying the enthusiasm when it starts to lag a bit because the work can be a real grind.”</td>
</tr>
<tr>
<td>Ensuring group remains on task (and things are not missed)</td>
<td>“...getting your group together properly.”</td>
</tr>
<tr>
<td>Keeping group members informed</td>
<td>“...all the right people were informed...”</td>
</tr>
</tbody>
</table>

A key observation was that it is not necessarily the responsibility of one person to perform all of these facilitative activities. It tends to be shared across a number of different individuals on various levels. Facilitation was perceived by participants as a team effort. Some illustrative comments included: “The idea that sort of runs through my mind is there are a number
of people fulfilling these roles.” Further, this participant said, “...I see different people fitting into different pieces of this.” Another’s idea was that “...the whole facilitation of this, it’s really a team effort. It has, you know to, to make it successful you need a team to carry all this out.” Similarly, another participant said, “Unless you have a working team, it’s not going to work.”

However, when asked whether the emphasis is more on facilitation as a process rather than as an individual performing the facilitator role, one participant felt that there still is a need for “...some identified body” as “...someone does have to coordinate the whole thing.”

Facilitators articulated several additional comments on facilitation related to process. These areas were not perceived as evident in the case-audit documentation and were described as follows:

1. Making sure the correct people are involved in the project: to ensure individuals with appropriate skill sets and content experts are included as well as to obtain buy-in.
   
   - One facilitator stated, “...we make sure the front-line staff and everyone’s there but it’s actually the managers and the hospitals and the administrators who actually have to be at the table.” This participant went on to say, “It’s great to get the staff online, which we do fairly well for implementing change, but we often forget the people who are actually making the decisions.”

2. Capacity-building: helping cases to understand the guideline adaptation and implementation process and to develop skills and knowledge in these areas.
   
   - One local facilitator commented that as groups gain experience, the work “...then supports itself.” Facilitation can then “...become more of a project management kind of role and ensuring that things are followed up and you know, move more into the evaluative type of work and start up other groups that have no experience.”
3. Developing a close working relationship with the project lead or co-lead: this relationship was seen as a particularly important dynamic in driving the projects forward. A good relationship between these individuals and good communication was seen as a success factor and all participants agreed that “Without it, your project would fail.”

4. “Having access to a venting office”: as the adaptation process can take a lengthy period of time and many cases get frustrated with this. This was noted by both local and external facilitators in that local facilitators encountered frustration voiced by members involved in the cases while external facilitators received “venting” from the local facilitators. Dealing with individuals’ frustrations and need to talk about specific issues was noted to be a constant occurrence.

- One local facilitator described her office as “…the venting office. People that I’m working with come in and they rant and rave and vent and they feel better and then you know, we move on.”

Specific enquiries were made into a few of the areas of facilitation for which little supporting evidence emerged from the case data. Information supporting some of these activities was also spontaneously shared throughout the focus group interview. For example,

- Taking on specific tasks did not emerge as a prominent part of the facilitator role. However, it was noted that facilitators end up “…doing the legwork and running around the building doing things rather than facilitating on a project-management level. Like, not just ensuring that other people are doing stuff on time. It’s like we’re actually, we’re doing that plus we’re actually doing it.”

- Creating an open, supportive, and trusting environment conducive to change was another one of these areas but facilitators felt that this was a part of what they do. This was
associated with being supportive and inclusive and letting group members know that their input is valuable.

- Empowering group members was also seen by facilitators as important although this was not recognized in the case-audit data. This involved not only empowering individuals but also entire groups.

Some other examples of activities vocalized as important by facilitators but not prominent in the case-audit data were relationship-building, teamwork, and helping to build in the structure and processes to support staff.

**Skills and knowledge for effective facilitation**

When asked what skills and knowledge are required for effective facilitation, participants were able to identify a range of expertise that they thought was essential. Several key attributes were repeatedly cited as central to the role:

1. Effective communication skills, ranging from maintaining regular close contact, ensuring the right individuals are informed and receive appropriate materials to a more complex awareness around communication on multiple levels. For example, one external facilitator described the need for “…a certain sensitivity and awareness around, particularly on multidisciplinary teams and sort of what the issues and challenges and context is around that requires a certain kind of communication sensitivity.”

2. Organizational skills, requiring military-style precision as described by one of the participants. Being organized and prepared, particularly for meetings, was seen as especially important. If meetings are not well-run and organized, group members’ time is seen as wasted and the project becomes further delayed. As one local facilitator commented, “It’s you can be as cheerful and as kind and fantastic as you want but if you’re not organized, you are dismissed. Like people will not pay any attention to you.”
3. Group dynamic and group leadership skills, involving making sure that everyone is heard, assisting the case with shared-decision making, and conflict resolution. One participant described the importance of having the ability “...to work with a group to achieve consensus and resolve conflicts.” This also included persuasiveness and negotiating skills.

4. “Relational practice skills,” also described as relationship skills. According to one participant, this involved “...making people feel comfortable to express themselves, teambuilding, support, encouragement...”

Discussion

This study set out to evaluate the facilitation activity occurring within a natural experiment of cases beginning an evidence implementation. We purposefully chose to concentrate on 3 cases adapting and planning for the implementation of guidelines designed to effect changes in nursing practice. Following a synopsis of the current state of knowledge on the concept as it relates to evidence implementation in nursing, facilitation was grouped into different stages and associated activities. These groupings were formulated into an audit tool that was used to explore if the practical nature of facilitation corresponded with facilitation as described in the literature. The activities of individuals whose role was designated as ‘facilitator’ were explored. We also tracked the facilitation activity performed by members of the cases in addition to the designated facilitators.

A combination of external and local facilitation was used with these cases. In two of the cases, external facilitators provided support and assistance primarily to local facilitators who in turn assisted cases. The other case required more direct external facilitation support and also exhibited more of the facilitation activities performed by case members themselves. More support may have been required because this case had limited resources and was engaged in a Pan-Canadian scope of implementation (as opposed to a local one). The large number of facilitative
activities engaged in by the case participants themselves may have been noted as the lead of this project was very involved in the adaptation process and worked very closely in collaboration with the local facilitator.

The practical elements emerging from the literature, described as 46 discrete activities, were in large part found as occurring in the 3 cases. There were only three activities in which no one, facilitators nor case members, engaged in. Two of these activities fell under the larger grouping of ‘evaluating change.’ This may be due to the fact that cases are only in the beginning stages of implementation and have not yet gotten to the point of evaluation. The third activity was ‘creating an open, supportive, and trusting environment conducive to change.’ Evidence for this activity may not have emerged in the documented data due to the nature of case-audit methodology since certain activities are not always observable on paper. Facilitators when asked, however, felt that this was part of their role. Further enquiry is needed to determine whether or not these elements actually represent facilitation in the practical sense and to further explicate the role of facilitation in the evaluation of evidence implementation.

An additional 5 new, distinct activities emerged in this study related to facilitation. The newly identified elements offer further insight into the role and process of facilitation. A fundamental issue in all study cases was that members involved in the projects performed certain activities of facilitation in conjunction with or in addition to local and external facilitators. This is central to the notion of facilitation being considered a process and not something to be expected only of an individual as facilitator.

The focus group interview augmented and built upon the findings of the case audit, reinforcing the elements of facilitation identified and offering new insights into the role and process. Although facilitators were appointed to their roles and each operationalized facilitation individually, all could relate to the activities and process identified. Participants also noted that a
range of requisite skills and knowledge is required for effective facilitation, providing practical examples from their experiences.

In line with Harvey et al.’s (2002) findings, facilitators working with these cases performed a vast array of activities ranging from practical, task-oriented assistance to providing holistic and enabling support. The results should be interpreted with caution as the facilitation activity was considered performed even if engaged in by one of the facilitators in one case. However, the activities were generally performed by facilitators across cases. The activities engaged in by local and external facilitators across all cases could be considered key elements of the process (see Table 6). When asked, facilitators themselves spontaneously identified many of these same elements as important. Although these findings have limited generalizability beyond these cases, they support the understanding of facilitation in the literature and add strength to descriptions of the concept.

Administrative and project management emerged as important aspects of facilitation. It was noted in the case data that facilitators organized, scheduled and often led meetings and were influential in ensuring the case remained on task. The potential overlap between facilitation and project management has been noted by other authors (Stetler et al., 2006). This has been previously explained in a different sense whereby facilitators are described as project leads (Rycroft-Malone et al., 2004). The context in our study was different. In addition to a dedicated local facilitator, each of these cases had an appointed project lead selected for the position due to their experience with guideline development and/or content area expertise. Participants in the focus group interview recognized that case members, particularly project leads, do not have the time to carry out these administrative tasks of organizing meetings and the follow-up associated with keeping cases on track. Therefore, these tasks were taken on by the facilitators in all cases.
These findings have important implications for those planning an evidence implementation. It is important to consider the different roles of all individuals involved in these projects. Recognition of the range of activities involved in facilitation and corresponding requisite knowledge and skills will be useful for selecting individuals to fulfill this type of role and in developing facilitator training programs.

Our findings are consistent with the definition presented earlier that was put forth by Stetler and colleagues (2006). Across cases, both local and external facilitators engaged in activities related to problem-solving and addressing specific issues and provided ongoing support and reassurance to case members. This is reflective of the two elements highlighted in Stetler et al.’s definition.

As well, facilitators perceived effective communication and relationship-building, particularly with project leads, to be key elements of the role. In a practice environment, the lead(s) might be the unit quality council or nurse manager who leads an implementation. The audit data also reflected the importance of communication. Both local and external facilitators fulfilled most of the activities under ‘effective communication’ according to the audit tool and provided regular communication and kept case members informed across all 3 cases. As described in the literature, enhancing relationships and fostering relationship-building are components of facilitation (Nagykaldi, Mold & Aspy, 2005; Tucker et al., 2006), along with themes of strong interpersonal and communication skills (Harvey et al., 2002; Stetler et al., 2006, Thompson et al., 2006).

A key observation in this study is that facilitative activities tend to be shared across a number of different individuals. This validates what was discovered in the literature review that facilitation is now being viewed as both an individual role as well as a process involving individuals and groups (Dogherty et al., 2009, under review). Facilitators perceived facilitation as
a team effort. This is important to consider in planning implementation projects in relation to evaluating both the strengths and weaknesses of group members and ties into ensuring the correct individuals are involved. It was identified that there is a need for a recognized individual, such as a facilitator, to coordinate the group. However, groups may bring their own assets and possess certain facilitative skills which could be capitalized on.

For instance, Kitson and colleagues (1998) originally proposed that facilitators play a key role in helping individuals understand what they need to change and how to make these changes to incorporate evidence into practice. Our results indicated that case participants themselves were able to identify a need for practice change recognized as a priority by staff. This may have been because the case participants had already identified an area for change prior to volunteering to participate in the guideline adaptation process. However, it begs the question of whether there are certain activities of facilitation that are more applicable if facilitated by the case participants themselves, provided they have the internal capacity and resources. As most participants had no issues with identifying a problem area in their clinical practice, facilitators were able to spend more of their time focusing on assisting cases with ‘how’ to change practice as opposed to finding ‘what’ needs to be changed.

Group members in all cases also played a substantial role in identifying a leader for their respective projects. This may be another area of facilitation, in some cases, more appropriate for group members to address themselves. Cases may be more cognizant of who amongst their colleagues would make a qualified leader as opposed to a facilitator being brought in to assist a group with a particular project.

Study Limitations

The study findings should be interpreted in consideration of some limitations. First, the data gathered in the focus group interview were self-report and as these individuals were
appointed or hired for the role, this may have had an effect on their responses. It may have been beneficial to also seek the case participants’ perceptions on facilitation. Secondly, a potential source of bias was encountered in that one author (EJD) extracted data from the case manuals and categorized the evidence. Finally, we observed the facilitation taking place in 3 in-depth cases in the early stages of evidence implementation activity (e.g. guideline adaptation and implementation planning) with a focus on adapting guidelines for use by nurses. As well, cases were focused on one area of care (cancer care), which may limit generalizability as there are distinct health delivery and system features in this area. Context is an important factor that relates to the facilitation approach taken; thus, the facilitation occurring in these cases may not be generalizable to other points in the implementation process or in other situations or settings. Facilitation may or may not be somewhat different in other areas of care.

Using multiple methods, we attempted to lessen bias through triangulation of the study results. Data collected included group processes (e.g. meetings, communications as well as self-reports, field notes, etc.) and a focus group interview with facilitators. To lessen the effect of potential bias in having one author interpret and categorize the evidence, the data manager checked the evidence supporting the categories and confirmed or challenged these interpretations. A detailed record of this discussion was kept. As well, facilitators’ perceptions were sought as to whether these categories and activities fit or were misrepresented based on their own experiences. The context of the cases is described in detail in order to inform potential transferability of the findings.

Conclusions

This study highlights some of the key, practical elements of the concept of facilitation as a role and process in early implementation of EBP in nursing. The distinct facilitation activities identified and facilitator perceptions offer a comprehensive description of the concept in a real
situation. Practical aspects of facilitation expand what is known and further validate what has been previously noted in the literature. With a better understanding of what facilitation entails, future research should concentrate on evaluating the effectiveness of facilitation interventions, both local and external, in influencing changes in nursing practice. This will not be easy as facilitation is a multifaceted and complex role and process. Therefore, it is important that the research methods and facilitation intervention employed in future research be described in detail. A range of requisite knowledge and skills for effective facilitation has been identified but there is also a need for determining the relative importance of the different combination of skills required for effective facilitation. This information could then be utilized to develop and expand the contribution of facilitation as a means of bridging the gap between research and practice.
References


CHAPTER FIVE

Revisiting and Reconceptualising Facilitation

This chapter describes how the provisional framework further evolved based on the case audit and focus group interview data. Facilitation data from the case audit provided the documented experience of facilitating guideline adaptation and implementation planning. The focus group interview elicited the actual experience of facilitation in facilitators’ own words. As part of the focus group interview, facilitators in the Partnership study reported their impressions of the provisional framework, providing further grounded experience to the conceptualization of facilitation in the framework. In this chapter, I will discuss how the theoretical and empirical understanding gathered from the literature was integrated with data from those actively involved in facilitation to refine the provisional framework. The revised framework is introduced, representing a comprehensive view and understanding of facilitation of evidence-based practice (EBP) in nursing which incorporates both theoretical and experiential perspectives.

The overarching aim of the thesis research was to describe facilitation as a role and process in the implementation of EBP in nursing. The aim was to develop a conceptual framework for practical use in carrying out facilitation. Through the framework, I sought to depict the multifaceted nature of facilitation and elucidate its key, practical elements to help practitioners enhance efforts to implement evidence into nursing practice. Initially, a provisional framework was developed based on the results of the focused literature review. This version of the framework was brought forth to the thesis committee for further feedback and subsequent revision. Using case audit and focus group methodologies, I then investigated the actual, active experience of facilitation of EBP in nursing (Chapter 4). The framework was presented to facilitators participating in the Partnership study as part of the focus group interview. The key elements of facilitation evident from the case audit and focus group interview findings were then
used to refine the initial conceptualization of facilitation. The revised framework integrates all of these perspectives and iterations to offer a comprehensive view of the concept. The framework resulting from the research is intended to guide practitioners and organizations in planning for change through the use of evidence.

Initial Refinement of the Framework

The provisional framework, developed based on the focused literature review, was brought forth to the thesis committee for feedback and further discussion (see Figure 5). The framework was subsequently revised, resulting in the second iteration (see Figure 6). Several key changes were made and additional elements incorporated:

1) It was decided by the committee that ‘outcomes’ should be included in the framework as evidence implementation has an impact on health and system outcomes.

2) ‘Context’ and its associated elements were viewed as encompassing everything in the diagram. Therefore, it was decided that ‘context’ should be represented by a large square in which facilitation, evidence implementation, and resulting outcomes all take place. The grey circle, which was previously denoted as ‘context’, was changed to represent ‘facilitation’ with the ‘roles/activity’ boxes placed inside.

This revision of the framework depicts facilitation as a means of moving evidence into practice which in turn, may result in certain outcomes (system, patient, and provider).

‘Facilitation,’ the grey circle, takes place within a certain context or setting which is why it is situated in the larger square denoting ‘context.’ The boxes within the grey circle indicate the roles/activities of facilitation. The boxes are connected to one another by double arrows intended to convey that the process is not linear but iterative in nature.
Figure 6. Facilitation in evidence-based practice in nursing – Provisional framework (second iteration).
Method

With the empirical and theoretical conceptualization of facilitation derived from the literature formulated into a provisional framework, the next step was to integrate the actual, active experience of facilitation discovered in the case audit and focus group interview. As described in the previous chapter, I conducted a case audit to examine the facilitative behaviours and activities occurring within 3 cases taking part in the Partnership study. This information was synthesized and formulated into a table to determine whether examples of the facilitation activity were performed and by whom, which allowed for the evaluation of commonalities in the data (e.g. in two cases, external facilitators performed the action whereas in the other case it was the local facilitator) (see Appendix C).

I examined the results table looking for concentrations of facilitation activities. For example, the discrete activities which were performed by both external and local facilitators as well as by group members across cases (as these were areas with substantial facilitation activity occurring). Then, I examined the important elements of facilitation identified by facilitators in the focus group interview and noted the corresponding activities. These data were used to confirm, refute, or revise the elements of facilitation identified in the literature and displayed in the ‘roles/activity’ boxes in the provisional framework. Finally, facilitators’ perceptions of the skills required for effective facilitation were incorporated.

The focus group interview was also used to gather feedback from participants on the second iteration of the framework and specifically, whether the diagrammatic display of facilitation and related concepts had meaning based on their practical experiences. Participants were asked to consider it a guiding framework and in doing so, 1) identify what practitioners or individuals would need to know if they were going to engage in facilitation, and 2) the critical elements that they need to understand or recognize. The remainder of this chapter presents the
findings and perspectives gathered based on the results of the case audit and focus group interview and describes how this information was integrated and used to modify the conceptual framework.

Reconceptualising Facilitation

Synoptic table revision

It should be noted that the synoptic table of facilitation (see Figure 7), which accompanies the framework, was modified based on the facilitators’ comments in the focus group interview. New facilitation activities identified in the case audit were already included in the table following a discussion between the Partnership study data manager and myself on where to integrate these items. The elements of facilitation not perceived by facilitators as evident in the case-audit documentation were considered for inclusion in the table as follows:

- **Identifying a qualified leader**: ‘qualified’ was added to ‘identifying a leader’ to emphasize the importance of selecting the right individual for the role.

- **Making sure the correct people are involved**: this element was added under ‘project management’ below ‘identifying a leader’ as not only did facilitators identify a need for the right leader, but also a need to consider individuals with appropriate expertise for inclusion in the group as a whole.

- **Capacity-building**: I perceived that developing group members’ skills, knowledge, and capacity fell under the activity of ‘enabling individual and group development.’ ‘Capacity-building,’ in brackets, was added to this element.

- **Developing a close working relationship with the project lead**: I saw this as part of ‘relationship-building.’ Thus, nothing was added or removed.

- **Access to a venting office**: I perceived that allowing group members to voice their frustrations with the change process was associated with ‘providing ongoing
support/reassurance and constructive feedback.’ Again, nothing was added or removed from this activity.

The revised table displays the activities of facilitation identified in the theoretical and empirical literature as well as information obtained from those actively involved in the process of facilitating EBP in nursing.
**Figure 7. Revised synoptic table of facilitation of EBP in nursing.**

<table>
<thead>
<tr>
<th>1) Planning for change</th>
<th>2) Leading and managing change</th>
<th>3) Monitoring progress and ongoing implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increasing awareness</strong></td>
<td><strong>Knowledge and data management</strong></td>
<td><strong>Problem-solving</strong></td>
</tr>
<tr>
<td>1.1 Highlighting a need for practice change</td>
<td>2.1 Knowledge translation/dissemination (assisting with conducting literature searches, obtaining articles, appraising and summarizing the evidence)</td>
<td>3.1 Problem-solving and addressing specific issues</td>
</tr>
<tr>
<td>1.2 Selecting an area for change relevant to staff/recognized as a priority</td>
<td>2.2 Helping to interpret the research and apply it in practice</td>
<td>3.2 Making changes to the developed plan as necessary</td>
</tr>
<tr>
<td>1.3 Stimulating critical inquiry and assisting groups to develop/refine specific clinical practice questions</td>
<td>2.3 Providing resources/tools for change</td>
<td>3.3 Networking</td>
</tr>
<tr>
<td>1.4 Assisting with/performing a formal/informal practice audit</td>
<td><strong>Project management</strong></td>
<td><strong>Providing support</strong></td>
</tr>
<tr>
<td>1.5 Interpreting baseline data and providing feedback/insight into performance gaps</td>
<td>2.4 Identifying a qualified leader</td>
<td>3.4 Mentoring and role-modelling EBP</td>
</tr>
<tr>
<td>1.6 Emphasizing enhanced patient outcomes as opposed to poor practice as reason for change</td>
<td>2.5 Making sure the correct people are involved</td>
<td>3.5 Maintaining momentum and enthusiasm</td>
</tr>
<tr>
<td><strong>Developing a plan</strong></td>
<td>2.6 Establishing and allocating roles/delegating responsibilities</td>
<td>3.6 Acknowledging ideas and efforts</td>
</tr>
<tr>
<td>1.7 Goal-setting and assisting with development of an action plan</td>
<td>2.7 Advocating for resources and change</td>
<td>3.7 Providing ongoing support/reassurance and constructive feedback</td>
</tr>
<tr>
<td>1.8 Helping identify and determine solutions to address potential barriers to EBP</td>
<td><strong>Recognizing the importance of context</strong></td>
<td>3.8 Empowering group members</td>
</tr>
<tr>
<td>1.9 Displaying and generating enthusiasm at the start of the project</td>
<td>2.8 Creating an open, supportive, and trusting environment conducive to change</td>
<td>3.9 Providing advice/guidance/assistance</td>
</tr>
<tr>
<td>1.10 Thinking ahead in the process</td>
<td>2.9 Helping to build in the structures/processes to support staff and help them overcome obstacles</td>
<td>3.10 Being available as needed</td>
</tr>
<tr>
<td><strong>Fostering team-building/group dynamics</strong></td>
<td>2.10 Creating local ownership of change</td>
<td>3.11 Ensuring group remains on task and things are not missed</td>
</tr>
<tr>
<td>2.14 Relationship-building</td>
<td>2.11 Assisting with adapting evidence to the local context</td>
<td><strong>Effective communication</strong></td>
</tr>
<tr>
<td>2.15 Encouraging effective teamwork</td>
<td>2.12 Boundary-spanning (addressing organizational systems/culture), managing the different requirements of each discipline/role</td>
<td>3.12 Providing regular communication (emails, phone calls)</td>
</tr>
<tr>
<td>2.16 Enabling individual and group development (capacity-building)</td>
<td>2.13 Tailoring/adapting facilitation services to the local setting</td>
<td>3.13 Keeping group members informed</td>
</tr>
<tr>
<td>2.17 Encouraging/ensuring adequate participation</td>
<td><strong>Administrative and project-specific support</strong></td>
<td>3.14 Acting as a liaison</td>
</tr>
<tr>
<td>2.18 Increasing awareness of and helping overcome resistance to change</td>
<td>2.20 Organizing/scheduling meetings</td>
<td><strong>4) Evaluating change</strong></td>
</tr>
<tr>
<td>2.19 Consensus-building (shared decision-making)</td>
<td>2.21 Leading/participating in meetings</td>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>2.22 Gathering information and assembling/distributing reports and materials</td>
<td>4.1 Performing/assisting with evaluation</td>
</tr>
<tr>
<td>4.2 Linking evidence implementation to patient outcomes</td>
<td>2.23 General planning</td>
<td>4.3 Acknowledging success, recognizing and celebrating achievements</td>
</tr>
<tr>
<td>4.3 Acknowledging success, recognizing and celebrating achievements</td>
<td>2.24 Providing skills training</td>
<td><strong>3) Monitoring progress and ongoing implementation</strong></td>
</tr>
<tr>
<td><strong>Effective communication</strong></td>
<td>2.25 Taking on specific tasks</td>
<td><strong>Problem-solving</strong></td>
</tr>
<tr>
<td>3.12 Providing regular communication (emails, phone calls)</td>
<td><strong>Providing support</strong></td>
<td>3.1 Problem-solving and addressing specific issues</td>
</tr>
<tr>
<td>3.13 Keeping group members informed</td>
<td>3.4 Mentoring and role-modelling EBP</td>
<td>3.2 Making changes to the developed plan as necessary</td>
</tr>
<tr>
<td>3.14 Acting as a liaison</td>
<td>3.5 Maintaining momentum and enthusiasm</td>
<td>3.3 Networking</td>
</tr>
<tr>
<td><strong>Recognizing the importance of context</strong></td>
<td>3.6 Acknowledging ideas and efforts</td>
<td><strong>Effective communication</strong></td>
</tr>
<tr>
<td>2.8 Creating an open, supportive, and trusting environment conducive to change</td>
<td>3.7 Providing ongoing support/reassurance and constructive feedback</td>
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<td>2.9 Helping to build in the structures/processes to support staff and help them overcome obstacles</td>
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<td>3.13 Keeping group members informed</td>
</tr>
<tr>
<td>2.10 Creating local ownership of change</td>
<td>3.9 Providing advice/guidance/assistance</td>
<td>3.14 Acting as a liaison</td>
</tr>
</tbody>
</table>
Figure 7. (continued).

<table>
<thead>
<tr>
<th>SKILLS AND ATTRIBUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tact and sensitivity; political, negotiation, and conflict management skills; marketing skills; having vision; project planning skills; innovation and resourcefulness; keen and able to generate interest; positive and confident; ability to act as a catalyst for change; active listener; strategic thinker</td>
</tr>
<tr>
<td>knowledgeable and experienced; critical thinking and appraisal skills; knowledge of research methods and process and data analysis; motivating, enabling, and energetic; flexible and adaptive (knowing when to take over and complete tasks and when to assist and enable clinicians to complete the tasks themselves); leadership skills; project management skills; ability to secure and obtain adequate resources; reliable; authority/status and ability to influence change in practice; authentic and credible (locally and clinically); understanding of the local context as well as the larger organizational context (unit and organizational culture/infrastructure/vision/values); interpersonal and interaction skills; group management and team-building skills; computer/IT skills; organized; teaching skills</td>
</tr>
<tr>
<td>supportive, encouraging, and empathetic; problem-solving; persistence and patience; networking skills and appropriate contacts; consistent and available; committed and responsive; communication skills</td>
</tr>
<tr>
<td>non-judgmental; analytical skills</td>
</tr>
</tbody>
</table>
Facilitators’ perceptions of the framework

When presented with the second iteration of the framework, facilitators agreed that the layout of the actual facilitation process made sense (see Figure 6). As one facilitator commented:

“...there’s this flow kind of that starts with planning and goes through you know the, the project management and then looking at the implementation and then evaluating. There might be, it might be iterative. There might be some cycles in there, but there is sort of one trending direction...”

Participants understood and related to the two-way arrows connecting the ‘roles/activity’ boxes because “...once you get into this you realize well, it’s not a perfect linear kind of progression. It’s like you go back and forth...” One participant also thought the roles and activities contained within these boxes were representative of and central to facilitation. She felt that every single activity relating to facilitation as displayed in the synoptic table could not be included in the framework as it would be too much to observe and understand.

In addition to providing positive feedback on existing elements within the framework, participants also identified areas that they felt were confusing and required clarification or changes. In particular, they mentioned:

1) There is a need to address that facilitation is a team effort and that it is not necessarily a ‘facilitator’ expected to perform and engage in all of the various activities.

2) The framework lacks a starting point. Participants felt that they did not know where to begin to look at the diagram. The suggestion was made to number the ‘roles/activity’ boxes (e.g. ‘1) Planning for change, 2) Leading and managing change,’ and so on).

3) There was considerable confusion regarding the orange arrows on the outer ‘facilitation’ circle and the blue arrows inside the circle connecting the ‘roles/activity’ boxes. It was
unclear to facilitators why the orange arrows connecting evidence, practice, and outcomes appeared to be moving in a counter-clockwise direction while the blue arrows and ‘roles/activity’ boxes were moving in a clockwise direction.

4) There is a need to highlight “…the knowledge translation, like where you take what is basically evidence and turn that into something that can be put into practice.” This participant suggested that this might fit on the outer circle connected to evidence, practice, and outcomes.

5) Several issues around the implementation piece were perceived as missing. One participant described the guideline as moving into practice with clinicians and following that, there would be an area or place where clinicians would provide feedback. Another facilitator commented that “…maybe that practice bubble is like the implementation bubble in my mind.”

Another noteworthy comment made in the focus group interview, but not in reference to the framework, was that there are different levels of evaluation in this type of work. There is evaluation of the actual guideline or evidence implemented and associated patient outcomes. However, there is also evaluation of the actual implementation process and investigating what worked and what did not work.

Queen’s Point-of-Care Facilitation Framework (QPCFF)

The framework was given a title and acronym and many changes were made based on the case audit and focus group interview findings as well as my own further interpretations of the concept of facilitation (see Figure 8).
For example,

- ‘A team effort’ was added below ‘facilitation’ to indicate that the process involves teamwork. As well, ‘engaging a team’ was added to the framework under ‘planning for change.’

- The framework was revised with ‘facilitation’ and the ‘roles/activity’ boxes placed on a straight line moving from left to right. Similarly, ‘evidence, practice, and outcomes’ were also placed on a straight line moving from left to right. Now it is easier to see how facilitation moves along with the evidence implementation process (e.g. ‘planning for change’ was placed below and just prior to ‘evidence’ as identifying the practice issue and planning for change often starts before cases begin to look at the evidence; as well,
the process results in outcomes, which is associated with ‘evaluation’ that was placed as such underneath ‘outcomes’). Additionally, numbers were added as suggested to the ‘roles/activity’ boxes (e.g. ‘1) Planning for change,’ etc.). This attempted to lessen the confusion associated with the previous diagram where the arrows were moving counter-clockwise and clockwise with facilitators not knowing where to begin to look at the diagram.

- A box was included between the ‘evidence’ and ‘practice’ circles titled ‘evidence-informed tool/product.’ This box was inserted to highlight the knowledge translation piece that one of the facilitators perceived to be missing. At this point in the process, the evidence is translated into something that can be used for practice (e.g. guideline, algorithm, etc.). Another box was also added after ‘practice’ called ‘adoption.’ This was intended to convey the process of adoption that occurs after evidence meets practice.

- ‘Implementation’ was placed as an umbrella encompassing the elements of the evidence-based tool, practice, and adoption. As well, ‘feedback’ was added between ‘practice’ and ‘outcomes’ to indicate that once the evidence goes into practice, feedback should be gathered from providers, patients, and the organization to determine implementation outcomes.

- The framework now includes a small box in the lower right-hand corner outlining some of the key skills required for effective facilitation as identified in both the literature and by facilitators in the facilitation study.

- The ‘roles/activity’ boxes represent the 4 major stages of facilitation and 11 groupings of activities developed based on the literature review. I decided that it was important to include several additional, specific activities which seemed central to the role (facilitator).
and process (facilitation) according to the case audit and focus group interview. As described earlier, I examined the case-audit data for concentrations of facilitation activity occurring across cases within each of the four stages of facilitation and determined if any of these activities were also emphasized by participants in the focus group interview. From this process, I identified four activities: gathering information and assembling/distributing reports and materials, maintaining momentum and enthusiasm, ensuring the group remains on task and things are not missed, and keeping group members informed. These activities were added to the boxes in the framework. As well, in the ‘evaluating change’ box, the different levels of evaluation were specified (e.g. process, guideline, etc.).

The revised framework presents facilitation as a team effort to help practitioners implement evidence into nursing practice. The facilitation process begins with helping practitioners to identify a need for change and/or to develop a plan to carry out the evidence implementation and ends with helping them to evaluate the outcomes of the change process. Facilitators or individuals engaging in facilitation perform a number of activities throughout the change process as indicated in the boxes. The boxes are connected by double arrows indicating that the process is not linear but iterative in nature. The assumption is that individuals or groups go back and forth between stages throughout the facilitation process. It is noteworthy that the facilitation approach is dependent on the context in which change is taking place. As such, ‘context’ and its associated elements encompass both the ‘facilitation’ and evidence implementation processes.

In summary, the QPCFF provides a comprehensive view and understanding of facilitation of EBP in nursing. Importantly, the framework integrates both theoretical and experiential
perspectives of the concept. This new framework provides insight into the practical nature of facilitation and may be useful to guide and inform practitioners and organizations in planning for change.
CHAPTER SIX

Summary and Implications for Practice and Future Research

This final chapter integrates and summarizes the results of the thesis research. Key findings are noted and discussed in relation to current literature in the field. I will present implications for nursing practice and policy as well as areas for future research to advance the facilitation of evidence-based practice (EBP) in nursing. Recommendations for nursing settings interested in active facilitation of EBP were developed and are presented.

My interest in this area arose when an initiative to implement evidence-based teaching tools in my work setting failed. All of the energy and resources invested in the initiative to make it successful seemed wasted. Therefore, I wanted to examine how things could have been done differently and how it could be made easier for nurses to implement evidence into their daily practice. If the barriers to nurses using research in practice are well-known, the next step is to begin to develop and analyze the effectiveness of different types of interventions to enhance the use of evidence in practice (Titler, 2004). This led me to the discovery of a conceptual framework developed by Kitson, Harvey, and McCormack (1998) which proposes that the successful implementation of research into practice is dependent on the relationship between three key factors: the nature and level of the evidence, the quality of the change context, and facilitation. Facilitation is a strategy that may enhance research use in practice. However, from a front-line nursing perspective, what is actually involved in facilitation is poorly understood.

Overview of Findings

The aim of the thesis was to describe facilitation in moving evidence into nursing practice and to determine the nature and dimensions of the role and process as described in theory and as actually experienced in order to develop a conceptual framework. The thesis findings suggest that
facilitation is a multifaceted process which plays a role in the implementation of EBP in nursing. The framework development process was iterative. The results of the literature review were used to develop a provisional framework where the activities and skills of facilitation of EBP in nursing were denoted. The provisional framework then guided the case audit and focus group interview with facilitators of cases involved in active facilitation. Subsequently, the framework was revisited and revised based on the results of the facilitation study described in Chapter 4. Facilitation was then reconceptualised to represent a comprehensive view of facilitation of EBP in nursing though integration of both theoretical and experiential perspectives (Chapter 5).

The literature review in Chapter 2 provided context and guidance for the provisional framework that subsequently informed the facilitation study described in Chapter 4. I chose to focus on 3 cases that were adapting a guideline for nurses and planning for implementation. The results of a case audit and focus group interview with facilitators in the field indicated that facilitation encompasses a wide range of activities of which communication and relationship-building are important elements. Five unique, additional facilitation activities were noted which were associated with the supportive aspect of the role. In particular, the facilitators being available as needed and ensuring groups remained on task were important supportive elements. As well, administrative and project management were seen as key to driving the evidence implementation forward. A noteworthy observation was that facilitation was perceived as a team effort and the activities were shared amongst a number of individuals and not simply one person’s responsibility. Participants identified a range of requisite skills and knowledge required for effective facilitation and provided practical examples from their experiences (e.g. good communication skills, organizational skills, etc.).
This study further validates what has been previously noted in the literature and offers new understandings about the practical nature of facilitation. Current literature describes facilitation as supporting and enabling practitioners to improve practice through evidence implementation (Dogherty, Harrison & Graham, 2009, under review). Facilitation has largely been viewed as being achieved by a person carrying out a specific role (Dogherty et al.). What is evident in recent literature and also in the results of this study is that facilitation is seen as both a specific role (e.g. that of a facilitator) as well as a process (e.g. a team or group engaging in the process of facilitation). The results of this study support these findings in that facilitation was seen by study participants as a team effort. In all 3 cases, the audit data supported that case members performed certain facilitation activities in conjunction with or in addition to local and external facilitators. This is central to the notion of facilitation being considered a process and not something to be expected of an individual as facilitator.

The practical elements of facilitation that emerged from the literature, described as 46 discrete activities, were in large part found as occurring in the 3 cases. Similar to Harvey et al.’s (2002) findings, facilitators working with these cases performed a vast array of activities ranging from practical, task-oriented assistance to providing holistic and enabling support. The results of this study add to the growing emphasis on relationship-building and communication described in the literature (Stetler et al., 2006; Thompson, Estabrooks & Degner, 2006). In particular, facilitators in this study found that the facilitator fostering a good relationship with the project lead is important for success. As well, facilitators perceived that a certain communication sensitivity is necessary when working with multidisciplinary groups and teams.

Project management and administrative follow-up support are seen as important components of facilitation. The possible overlap between facilitation and project management has
previously been noted (Stetler et al., 2006). This is described by others in the sense where
‘facilitators’ are noted as project leads (Rycroft-Malone et al., 2004). The context of facilitation
examined in the thesis study was different. In addition to a dedicated local facilitator, each of the
cases had an appointed project lead selected for the position due to their experience with guideline
development and/or content area expertise. Participants in the focus group interview recognized
that case members, particularly project leads, do not have the time to carry out these
administrative tasks. Therefore, these tasks were taken on by the facilitators in all cases. While
important to note this overlap, the facilitators in this study acted in more of a supportive role than
a project leadership role. Both roles are important even though there may have been some overlap
between the activities of these individuals. This reinforces the emphasis on the facilitator role
being clearly defined and articulated (Stetler et al., 2006).

In reflecting upon facilitation in the implementation of EBP in nursing, it is interesting to
note that the facilitation process seems to parallel the nursing process. Facilitation, as I have
conceptualized it, begins with planning for change, then leading and managing change,
monitoring ongoing implementation, and finally evaluation. The nursing process is a systematic
approach to plan, implement, and evaluate care for patients, families, and communities. Similar to
facilitation as described above, the nursing process begins with assessment followed by planning,
implementation, and evaluation (College of Nurses of Ontario, 2009). The way I have structured
facilitation has value from a practical point of view as it may be easier for nurses to relate to and
understand the process in this way. In fact, one of the facilitators mentioned that the way in which
she approached and was able to understand facilitation and the evidence implementation project
was using the nursing process as her framework. She stated:

...I have viewed it in that way. That it’s a planning and just like in you know nursing
when you, when you assess. You see, ‘okay, what do we need?’ And then you plan. And
then you do your intervention, which is I guess in this case we’re making a guideline. And then you evaluate, ‘okay, what?’ And you evaluate different things. You evaluate the process. What worked? What didn’t work? What should we do better next time? You evaluate the actual guideline. Wow, how do we write it? You know, what needs to be pumped up next time? You know? We need better stats or whatever. And then you evaluate the outcome. The actual outcome of the effect of what you’re doing in the guideline to your patient population. So, that’s the way I understood it is that ‘wow, there’s all different levels of evaluation.’ So I like how your, how your layout here kind of, it makes sense to me. Because it’s following in my mind, nursing process.

This way of thinking may have been ingrained during nursing training but perhaps individuals have not considered it in the context of facilitation. As opposed to a patient, family, or community, facilitators work with a group to achieve different outcomes (e.g. evidence uptake). It was interesting to see some of the extent to which this facilitator saw facilitation as natural and intuitive as she does this type of thinking all of the time in her practice; it was just placing it into a different context.

As mentioned above, the facilitation process is similar to project management in some ways and there may be some overlap. However, viewing facilitation from this point of view poses certain challenges and requires careful consideration. Viewing evidence implementation and the accompanying facilitation as a specific project taking place over a certain time period runs counter to sustainability. When viewed in this way, facilitation would appear to finish at the end of each specific project. Sustainability of interventions and evidence implementation are paramount and it is important to recognize this when thinking about the facilitation process. Using and integrating new research evidence into practice needs to be ongoing, as new research is being conducted and reported on a regular basis. Nurses need to be continually reflecting on their practice and considering the evidentiary base upon which their clinical decisions are made in everyday patient care. Therefore, facilitation must continually operate and be sustained in a similar ongoing manner to enhance evidence uptake. Sustainability must be taken into
consideration and not overshadowed when viewing facilitation from a project management perspective.

Implications for Practice and Policy

Both nurses and organizations have a responsibility to provide care based on the best available evidence. Facilitation is one strategy to enhance evidence uptake in clinical nursing practice. Unfortunately, facilitation is applied in intervention and implementation studies without specific explanation of its meaning, which makes it difficult to replicate either in research or practice. The results of this study provide a categorization of facilitation activities which could be used to inform and develop specific facilitation interventions. With the knowledge of what facilitators are actually doing to enable changes in nursing practice in a real situation, the role and process can be operationalized in implementation studies and projects.

The finding that facilitation is a team effort offers consideration of existing groups and teams as avenues to support EBP without adding new resources. Key to success may be deputizing and authorizing this function. Organizations seeking to advance EBP need to identify how facilitation is going to happen, commit appropriate resources, and ensure the right people are involved in the process to promote and maintain change. Although a group may engage in the facilitation process, there is still a need for an identified individual such as a facilitator to ensure the group remains on task and momentum and enthusiasm are maintained. The composite of requisite skills and knowledge gathered in the literature review and resulting from the facilitation study is useful knowledge for both the selection of potential individuals to perform the facilitator role and to inform the development of facilitation training programs. The new framework and accompanying synoptic table provide a starting point for those beginning to plan and develop focused guidelines and training to support individuals and groups engaging in this process.
In summary, the framework depicts facilitation as a dynamic, multifaceted process in moving evidence into nursing practice. Understanding the nature of facilitation and its associated elements is important to consider when planning an evidence implementation. The advantage of this framework is in its ability to provide direction for practitioners and identification of the specific activities that could be employed during the implementation process.

Future Research

The results of this study highlight many areas for future research regarding facilitation as a role and process in the facilitation of EBP in nursing. There is a need for research on the outcomes and cost-effectiveness of facilitation interventions. No randomized-controlled trials were found assessing the effectiveness of facilitation on changing nursing practice. Rather, several trials have investigated the effectiveness of trained nurse facilitators in influencing changes in primary care general practitioners’ offices (Hogg et al., 2008; Hulscher et al., 1997; Lemelin, Hogg & Baskerville, 2001). These studies involved a number of staff, with nurses in some but not all practices, and the focus was primarily on medical practice. More theory and research is needed to conceptualize and evaluate facilitation in the context of changing nursing practice. Kitson (1995) suggests differences in cultural norms between medicine and nursing in relation to autonomy, peer review, and the ability to influence change in local practice, could mean that optimal implementation methods could be different for each group. As facilitation is a multifaceted approach, it is important that the research methods and facilitation interventions employed in future research be described in detail.

Further to Harvey et al.’s (2002) findings from their concept analysis of facilitation, questions about the sustainability of facilitation interventions remain unanswered. Nurses have identified that practice change would not be sustained without ongoing support (Ruston, 2002).
There is a need to evaluate the sustainability of ongoing facilitation strategies and what structures and processes need to be in place to maintain practice change.

To further advance this area of EBP, the facilitation framework developed in this study requires further exploration and testing to refine the existing elements as well as examine the importance of the new elements of facilitation identified. Further enquiry is needed to determine the relative importance of the various elements in the practical sense and to further explicate the role of facilitation in the entire knowledge-to-action process. The cases involved in this study were focused on adapting a guideline and early planning for implementation. There is a need to evaluate facilitation throughout the entire implementation process to see if the role and process evolves over time. Ideally, facilitation should be followed through to evaluation. The thesis study cases had not yet reached this point in the evidence implementation. As noted previously in evaluating outcomes, the ability of nurses to make the connection between the evidence and patient care is important for success in getting research into practice (Doran & Sidani, 2007; Pepler et al., 2006) It is unclear what exactly facilitation entails in this evaluation process. There is a need to investigate the nature of the relationships outlined in the framework and particularly the relationship between contextual characteristics and components of facilitation interventions that might be used to better tailor facilitation to specific local settings.

Practice and Policy Recommendations

The conceptual framework developed by Kitson and colleagues (1998) is a useful broad framework for examining facilitation while the results of this thesis study provide insight into the discrete, practical elements to operationalize the concept. This enquiry began as I sought to develop practice and policy recommendations in reflecting upon what went wrong or could have been done differently in the failed evidence implementation at my former place of employment.
Based on the thesis research, I would offer the following recommendations to nursing settings interested in active facilitation of EBP:

- Develop a written action and work plan for change.
- Engage practitioners from the beginning of the change process to create a sense of ownership and generate an interest in the planned change.
- Clearly articulate the role and activities of individuals or groups participating in facilitation at the beginning of an evidence implementation. As multiple individuals may participate in the process, it is important that everyone is on the same page with respect to expectations and their responsibilities. Incorporate this information into the work plan.
- Carefully assess and account for the context where change is to take place when determining and selecting a facilitation approach.
- Identify barriers and resistance to change upfront and on an ongoing basis.
- Assist nurses to identify outcome indicators that are meaningful to their practice (e.g. improved airway management, earlier discharge, etc.) as well as system-level indicators (e.g. cost-savings, efficiencies, etc.).
- Provide opportunities for nurses to observe the patient outcomes (e.g. through audit and feedback) resulting from implementing evidence-based changes in practice.

Conclusions

Facilitation continues to evolve as an important element in advancing evidence-based nursing practice. This thesis has translated the concept into a more practical and applied function in the early implementation of EBP in nursing. Facilitation itself is considered a distinct
intervention on one level and on another it involves organizing and implementing other change strategies. The thesis contributes to the understanding of facilitation as a potential change strategy and the actual activities involved. The results of the study offer insight and understanding into what facilitation entails in relation to nursing and a starting point for future avenues of research in the area. The synoptic table serves as a foundation for further articulation of the concept.

Advancing nursing knowledge in the area provides information for developing and evaluating the effectiveness of facilitation strategies. Facilitation may be an important and critical strategy in and of itself to bridge the gap between research and practice. More transparency and detail about facilitation will contribute to systematically developing, implementing, and testing facilitation in nursing contexts. Facilitation is clearly an important intervention to advance evidence-based practice and the improved understanding of facilitation offered in this thesis provides a guiding framework for future investigations of evidence implementation where facilitation is a key element.
References


Appendix A

Facilitation case-audit tool
<table>
<thead>
<tr>
<th>Stage</th>
<th>Facilitation Activity</th>
<th>X = yes</th>
<th>Type of facilitation (who -&gt; recipient)</th>
<th>Details/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>Highlighting a need for practice change</td>
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<tr>
<td>for change</td>
<td>Selecting an area for change relevant to staff/recognized as a priority</td>
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<td></td>
<td>Stimulating critical inquiry and assisting groups to develop/refine specific clinical practice questions</td>
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<td></td>
<td>Assisting with/performing a formal/informal practice audit</td>
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<td></td>
<td>Interpreting baseline data and providing feedback/insight into performance gaps</td>
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<td></td>
<td>Emphasizing enhanced patient outcomes as opposed to poor practice as reason for change</td>
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<td></td>
<td>Assisting with development of an action plan</td>
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<td></td>
<td>Goal-setting and consensus-building (shared decision-making)</td>
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<td></td>
<td>Helping identify and determine solutions to address potential barriers to EBP</td>
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<tr>
<td>Leading and managing change</td>
<td>Knowledge and data management</td>
<td>Project management</td>
<td>Recognizing the importance of context</td>
<td>Knowledge translation/dissemination (assisting with conducting literature searches, obtaining articles, appraising and summarizing the evidence)</td>
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<tr>
<td>Administrative and project-specific support</td>
<td>Relationship-building</td>
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<td>-------------------------------------------</td>
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<tr>
<td>Fostering team-building/group dynamics</td>
<td>Encouraging effective teamwork</td>
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<td></td>
<td>Enabling individual and group development</td>
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<td>Encouraging/ensuring adequate participation</td>
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<td></td>
<td>Increasing awareness of and helping overcome resistance to change</td>
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<td></td>
<td>Organizing/scheduling meetings</td>
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<td></td>
<td>Leading/participating in meetings</td>
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<td></td>
<td>Gathering information and assembling reports</td>
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<td></td>
<td>General planning</td>
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<td></td>
<td>Providing skills training</td>
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<tr>
<td>Problem-solving</td>
<td>Problem-solving and addressing specific issues</td>
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<td></td>
<td>Making changes to the developed plan as necessary</td>
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<tr>
<td>Monitoring progress and ongoing implementation</td>
<td>Providing advice/guidance/assistance</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>Networking</td>
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<tr>
<td>Mentoring and role-modelling EBP</td>
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<tr>
<td>Maintaining momentum, direction, and enthusiasm</td>
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<tr>
<td>Acknowledging ideas and efforts</td>
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<tr>
<td>Providing ongoing support/reassurance and constructive feedback</td>
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<tr>
<td>Empowering group members</td>
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<tr>
<td>Providing regular communication (emails, phone calls)</td>
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<td>Keeping group members informed</td>
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<td>Performing/assisting with evaluation</td>
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<tr>
<td>Linking evidence implementation to patient outcomes</td>
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<tr>
<td>Acknowledging success, recognizing and celebrating achievements</td>
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Appendix B

Focus Group Interview Participant Consent Form
THEORETICAL AND EXPERIENTIAL PERSPECTIVES ON FACILITATING EVIDENCE-BASED PRACTICE IN NURSING: TOWARD A CONCEPTUAL FRAMEWORK

PARTICIPANT INFORMATION AND CONSENT

Start Date: September 18th, 2008

Primary Investigator: Elizabeth J. Dogherty, BNSc, RN, Queen’s University Master’s Student

Co-Investigator: Dr. Margaret B. Harrison, Thesis Supervisor, Queen’s University Faculty of Nursing

Purpose and Background
There is a gap in health-care between what is known and what is practiced due to the lengthy delay in incorporating research findings into clinical practice. Despite funding and resources put toward health science research resulting in continuous production of new knowledge, it may take as long as one to two decades before research evidence is incorporated into routine clinical practice. Facilitation has been proposed as an essential component to enabling successful implementation of research evidence into health care practice. In general, it is considered support provided to assist practitioners with identifying what needs to change in practice and how to make these changes. Facilitation may play an important role in bridging the gap between research and practice but from a practical perspective it has not been well understood or thoroughly investigated as it relates to evidence implementation in nursing. This is consequential as nurses are accountable for basing their practice on sound evidence.

The aim of this study is to describe facilitation in moving evidence into nursing practice in order to determine the nature and dimensions of the role and process in theory and from actual experience. This component of the study will be looking at the actual, active experience of facilitation. The focus will be on facilitation as manifested in the guideline adaptation process and more specifically on individuals and cases involved in active facilitation of nursing-focused, or nurse-involved, cancer guideline adaptation. The data collected will be used to refine a conceptual framework underpinning the role, function, and skills of facilitation of evidence-based practice (EBP) in nursing.

Procedures
I understand that by agreeing to participate in this study, I am indicating my willingness to participate in an audio-taped focus group teleconference with several other facilitators anticipated to last no longer than 30-45 minutes. The interviewer will ask several pre-determined questions about the facilitation framework but will also maintain flexibility to explore additional lines of enquiry as appropriate. Prior to the session, I will be provided with the provisional framework to review and several questions to consider before the focus group. I understand that I will be asked
to describe the characteristics of facilitation activity occurring in the guideline adaptation process as well as my experiences and thoughts regarding facilitation.

**Potential Benefits**
I understand that I may or may not benefit directly by participating in this study but there are some potential benefits to be considered. By participating in this study, I may reflect on and learn from my experiences as a facilitator as well as those of others in relation to guideline adaptation and evidence implementation in nursing. Additionally, a more clear and comprehensive awareness of what facilitators perceive they are actually doing to enable changes in nursing practice would lay the groundwork for the design of practical strategies for EBP in nursing where facilitation is a key element. Identifying what is required to facilitate the guideline adaptation and implementation process across different settings will provide useful guidance for those planning facilitation of evidence-based guidelines as means of improving patient care.

**Potential Risks**
I understand that there are no known or foreseeable risks to participating in this study. If I find that I have further questions, I can call the researchers who are conducting the study to discuss them.

**Confidentiality**
I understand that all of the information given by individuals participating in this study will be kept strictly confidential and will not be available to anyone but the study investigators. I will be assigned a study identification number to maintain confidentiality for the purposes of computerized data entry. One copy of my name and my study identification number will be kept in a locked drawer in the researcher’s office. All of the information gathered will be used for research purposes only. I also understand that I must respect the privacy and confidentiality of other participants in the study.

I am aware that excerpts from the focus group may be included in the thesis and/or publications originating from this research. It should be noted that the research does not pertain to an issue identified as particularly controversial or sensitive. I am being given the option of my responses remaining anonymous in any publication or presentation of the research findings or allowing the investigator to quote me by name (provided the quote is given to me to review beforehand):

I agree that information provided by me during the focus group may be directly quoted using my name, provided the quote is given to me to review prior to inclusion in any publication or presentation of the research results:

☐ YES ☐ NO

I would prefer direct quotes provided by me during the focus group to remain anonymous and not to reference my name or any other identifying information in any publication or presentation of the research results:

☐ YES ☐ NO
Financial Compensation
I understand that there is no financial compensation for participating in this study.

Contacts
I understand that if I have any questions or problems relating to this study, or would like additional information to assist me in reaching a decision about participation, I can contact:
Elizabeth J. Dogherty at (613) 583-0531 or by email at 9ejd1@queensu.ca or
Dr. Margaret B. Harrison, thesis supervisor, at (613) 533-6000 extension 74760 or by email at Margaret.B.Harrison@QueensU.ca or
Dr. Cynthia Baker, Director of the Queen’s University School of Nursing, at (613) 533-6000 extension 32669

This study has been reviewed and received ethics approval through the Queen’s University Health Sciences Research Ethics Board. If I have any questions about my treatment and rights as a research participant, I can contact:
Dr. Albert Clark, Chair of Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board, at (613) 533-6081

For further information about my rights as a research participant, I can visit the following website:
Queen’s University Affiliated Health Sciences Centre Research Ethics Board,
http://www.queensu.ca/vpr/policies/committee.html.

Right to Withdraw or Participate
I understand that my participation in this study is voluntary and I may refuse to take part or withdraw from this study at any time and for any reason by advising the researcher.

Consent
I have read and understand the consent form for this study. I have had the purpose and procedures of this study explained to me. My signature on this form indicates that I understand, to my satisfaction, the information about my participation in this study and that I agree to participate. In no way does this waive my legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

I ____________________________________________, the undersigned, am indicating that I agree to participate in this study. I have been given sufficient time to consider the above information and have had the opportunity to ask questions which have been answered to my satisfaction. I understand that my participation is voluntary and there is no guarantee that I will benefit from participating. I will receive a copy of this form for my information.

_____________________________________________   ______________________________
(Signature of Participant)                        (Date)

_____________________________________________   ______________________________
(Signature of Witness)                          (Date)
Statement of Investigator:

To the best of my ability, I have carefully explained to the participant the nature of this research study. I have invited the participant to ask questions and have provided answers. I certify that, to the best of my knowledge, the participant fully understands the nature of the research project, the implications, and voluntary nature of the study. I have also provided the participant with a copy of this form for his or her information.

________________________________________________________________________
(Signature of Principal Investigator)  (Date)
Appendix C

Data analysis tables – Facilitation activities performed across cases

(local, external, case members)
<table>
<thead>
<tr>
<th>Activity</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Focus Group Interview - elements emphasized</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Highlighting a need for change</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>2. Selecting a priority change area relevant to staff</td>
<td>L</td>
<td>E</td>
<td>C</td>
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</tr>
<tr>
<td>3. Assisting groups to develop practice questions</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<tr>
<td>4. Performing a practice audit</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
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<tr>
<td>5. Providing insight into performance gaps</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<tr>
<td>6. Emphasizing need to enhance patient outcomes</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
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<tr>
<td>7. Assisting with developing an action plan</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>8. Addressing potential barriers to EBP</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
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<tr>
<td>9. Generating enthusiasm at start or project</td>
<td>L</td>
<td>E</td>
<td>C</td>
<td></td>
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<tr>
<td>10. Thinking ahead</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<tr>
<td>11. Knowledge translation/dissemination</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<tr>
<td>12. Providing resources/tools</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<tr>
<td>13. Identifying a leader</td>
<td>L</td>
<td>E</td>
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<tr>
<td>14. Allocating roles/responsibilities</td>
<td>L</td>
<td>E</td>
<td>C</td>
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<td>15. Advocating for resources and change</td>
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<td>16. Creating an open, supportive environment</td>
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<td>17. Helping build in structures to support staff</td>
<td>L</td>
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<td>18. Creating local ownership</td>
<td>L</td>
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<td>19. Adapting evidence to local context</td>
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<td>20. Boundary-spanning</td>
<td>L</td>
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<td>21. Adapting facilitation to the local setting</td>
<td>L</td>
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<td>22. Relationship-building</td>
<td>L</td>
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<tr>
<td>23. Encouraging teamwork</td>
<td>L</td>
<td>E</td>
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<td>24. Enabling individual and group development</td>
<td>L</td>
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<td>25. Ensuring adequate participation</td>
<td>L</td>
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<td>26. Helping overcome resistance to change</td>
<td>L</td>
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<td>27. Consensus-building</td>
<td>L</td>
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<tr>
<td>28. Organizing meetings</td>
<td>L</td>
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<td>29. Leading/participating in meetings</td>
<td>L</td>
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<td>30. Gathering information/distributing materials</td>
<td>L</td>
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<td>31. General planning</td>
<td>L</td>
<td>E</td>
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<td>32. Providing skills training</td>
<td>L</td>
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<td>33. Taking on specific tasks</td>
<td>L</td>
<td>E</td>
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<td>34. Problem-solving/addressing issues</td>
<td>L</td>
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<td>35. Making changes to action plan as needed</td>
<td>L</td>
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<td>36. Networking</td>
<td>L</td>
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<td>37. Mentoring and role-modelling EBP</td>
<td>L</td>
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<td>38. Maintaining momentum and enthusiasm</td>
<td>L</td>
<td>E</td>
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<td>39. Acknowledging ideas and errors</td>
<td>L</td>
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<td>40. Ongoing support/reassurance</td>
<td>L</td>
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<td>41. Empowering group members</td>
<td>L</td>
<td>E</td>
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<td>42. Providing advice</td>
<td>L</td>
<td>E</td>
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<td>43. Being available as needed</td>
<td>L</td>
<td>E</td>
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<td>44. Ensuring group remains on task</td>
<td>L</td>
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<td>45. Regular communication</td>
<td>L</td>
<td>E</td>
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<tr>
<td>46. Keeping group members informed</td>
<td>L</td>
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<td>47. Acting as a liaison</td>
<td>L</td>
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<td>48. Assisting with evaluation</td>
<td>L</td>
<td>E</td>
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<td>49. Linking implementation to patient outcomes</td>
<td>L</td>
<td>E</td>
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<tr>
<td>50. Acknowledging success</td>
<td>L</td>
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</table>

**Type of facilitation**

- L = local facilitator
- E = external facilitator
- C = case members
Appendix D

Facilitation Study Ethics Approval
QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

September 18, 2008

This Ethics Application was subject to:
☐ Full Board Review
☐ Meeting Date:
☒ Expedited Review

Ms. Elizabeth Dogherty
School of Nursing
Practice and Research in Nursing Office
78 Barrie Street - Room 200
Queen's University

Dear Ms. Dogherty,

Study Title: Theoretical and experiential perspectives on facilitating evidence-based practice in nursing: toward a conceptual framework

Co-Investigators: Dr. Margaret Harrison

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair's signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

➢ Reporting of Amendments: If there are any changes to your study (e.g. consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval. (see http://www.queensu.ca/vpr/teb.htm).

➢ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➢ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➢ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair's signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

[Signature]
Chair, Research Ethics Board

[Signature]
Date

Study Code: NURS-226-08

➢ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete.
Appendix E

Permission to access Partnership case-series data
Ms Elizabeth Dogherty  
Masters Student (continuing)  
School of Nursing  
Queen’s University  
Kingston, Ontario K7L 3N6  

“*Theoretical and experiential perspectives on facilitating evidence-based practice in nursing: Toward a conceptual framework.*”

Dear Ms Dogherty,

As supervisor of your thesis research, I am pleased to grant you full and free access to data developed as part of the Canadian Partnership Against Cancer (CPAC) project, Queen’s University Health Sciences Research Ethics Board approval # NURS-211-07. Under the umbrella of this project, it is understood that you will conduct secondary analysis focusing on the role facilitation plays in advancing communities of care, and as it enhances implementation of research evidence into nursing practice.

It is understood that all publications resulting from the secondary analysis of this data will be discussed with and vetted by the Primary Investigator to ensure that data integrity is maintained and redundant reporting is avoided. I am confident that your analysis of this data will result in the exploration of an exciting but understudied topic.

Sincerely,

Margaret B. Harrison, RN PhD  
Professor, School of Nursing