FEATURE ARTICLE

ACCELERATING RESEARCH EVIDENCE TRANSLATION THROUGH DYADIC ENGAGEMENT: A DEVELOPING MODEL FOR EVIDENCE-BASED PRACTICE IMPLEMENTATION

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Abstract

Evidence-based practice (EBP) has been regarded as the gold standard of clinical practice in the health profession. However, even though the importance of EBP is well documented in the nursing literature, in developing countries, its implementation remains a challenge. In addition to individual and organizational barriers to EBP implementation, the existence of the academician-clinician divide is a critical concern. This seeming disconnect has significantly hampered the translation of knowledge into practice. Hence, collaborative dyadic engagements between the academician and clinicians have to be nurtured. The Accelerating Research evidence translation through Dyadic Engagement (ARDE) Model, a pragmatic way of facilitating the enculturation of EBP, is proposed and collaborative efforts in solving clinically relevant nursing issues will pave the way for EBP to become an integral part of clinical practice.

Keywords: *EBP, Academician, Clinician, Dyadic Engagement, Partnership, Model of Nursing*

Introduction

The dynamic nature of the healthcare delivery system requires practitioners to take bold and necessary actions to become relevant to the needs of the times. With changes underway, Evidence-Based Practice (EBP) is seen as a feasible approach that needs to be processed by healthcare professionals in all practice settings in making decisions to fulfill the quality demands of their practice (DePalma, 2010). The International Council of Nurses (ICN, n.d.) noted that in "in the era of EBP and knowledge-driven healthcare, nurses have a professional obligation to society to provide care that is constantly reviewed, researched, and validated." EBP is considered by the Institute of Medicine (IOM, 2001) as a core competency that all health professionals need, to meet the demands of the twenty-first-century healthcare system.

EBP is defined as "the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision-making" (DiCensa, Giliska, & Gyatt, 2005). While EBP is held as the gold standard for patient care (Luciano, Aloia, & Brett,2019), challenges exist in its implementation. A review of the literature reveals barriers at the individual and organizational level that prevent nurses from caring for their patients using current evidence. On one hand, barriers at the individual level include the lack of skill in evaluating the quality of research among nurses (Parahoo, 2009), lack of accessibility from knowledgeable colleagues with whom to discuss research (Nilsoon Kajermo, Nordtsrom, Krusebrant & Bjorvell, 1998), and lack of confidence to implement change (Parahoo, 2009). At the organizational level, obstacles include a lack of organizational support, interest, motivation, leadership, vision, strategy, and direction among managers (Parahoo, 2009). Additionally, Penz and Bassendowski (2006) enumerated present issues within the clinical practice setting that pose challenges. These include: (1) time factors where nurses feel they are too busy to take part in EBP activities, (2) lack of appropriate access to current information and the resources to support new knowledge (Ervin, 2002; Paramonczyk, 2005; Young, 2003), and (3) additional knowledge and skills required by nurse clinciians to critically

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appraise the findings from research and its effect on their practice (Ervin, 2002; McCaughn, Thompson, Cullum, Sheldon & Thompson, 2002; Paramonczyk, 2005). These barriers need to be addressed immediately for nurses to promote the best clinical practice. Varnell, Haas, Duke, and Hudson (2008) argued that nurses will more likely base their decision making on best evidence if knowledge on EBP of nurses in the clinical setting is well established.

It is apparent that there is a slow and inefficient transfer of research findings from "bench to bedside" and into improving health (Woolf, 2008; Livet et al., 2018; Seaton et al., 2017). Graham et al. (2006) noted that the translation of research findings to practice is more often than not slow and a haphazard process even with substantial resources has been dedicated to health science research. In fact, existing literature indicated that it takes more than a decade before new pieces of evidence are incorporated to practice (NCCMT, 2011; Luciano et al, 2019).

Having said that, the lag time between EBP's readiness for adoption and its actual implementation in the practice setting justifies that there is indeed a gap between research and practice. This sad reality of the theory/research-practice gap intensifies the clamor to veer away from the routine and ritual approach of care delivery and shifting into evidence-based practice. The existence of a theory-practice gap in nursing practice serves as a threat leading to the fragmentation of nursing practice. Nonetheless, this fragmentation can be mitigated or even eliminated with the use of EBP in clinical practice. For instance, the eventuality of bridging the gap between theory and practice as well as nurses thinking clearly and improving patient care is not a far-fetched reality. Bridging this gap through EBP may be challenging but it is undeniably beneficial (Billings & Kowalski, 2006). Palaganas (2012) highlighted in her editorial in the Philippine Journal of Nursing that there is an urgent call to constantly strive to use EBP in nursing services. Furthermore, it states that EBP attempts to bridge the research and nursing practice gap in different work settings and that it is a promising approach for more lasting solutions to deeply rooted gaps in healthcare (Palaganas, 2012).

The importance of EBP, as well as its relevant activities in developed countries like Australia, Canada, UK and USA, are well-documented in the literature. However, the principle of incorporating research evidence into practice is still in its infancy in developing countries (like the Philippines) (Dizon, Dizon, Regino, & Gabriel, 2014). The expectation of integrating research-based evidence into the nursing practice has yet to be fully realized and appreciated (Palaganas, 2018). This is backed up by a study that assessed the EBP beliefs and implementation of staff nurses in the Ilocos Region. The study concluded that those nurses in the Ilocos region are positive about their knowledge of, confidence in, and belief about EBP but are not fully committed to it. However, despite having positive EBP beliefs, their implementation of EBP was rare or low. Moreover, the study was able to elicit that EBP implementation is significantly associated with the held beliefs on EBP by the respondents (Arde, 2018). In addition, the study of Lumanlan (2018) among nurses in Angeles, Pampanga showed that nurses have a positive and above-average attitude toward EBP. However, results yielded that the respondents have average knowledge about it. The average knowledge in EBP might be due to limited opportunities for evidence-based capability-training and insufficient access to technical resources.

The results of these two studies magnified that nurses in the Philippines hold positive beliefs and attitudes towards EBP, which in turn can be a starting point to put more pressure on its implementation in practice. Palaganas (2009) underscored to take advantage of the enthusiasm that the nursing community has on EBP and the need to develop, implement, and evaluate plans to make it happen. Straus, Tetroe, and Graham (2009) suggested the need for extensive efforts in enhancing health outcomes through the use of effective interventions that close the gap of translating knowledge to practice. As faculty and clinical educators and leaders continue to seek strategies to teach EBP and support its adoption across the organization (Allen, Lubejko, Thompson, & Turner, 2015), and administrators strive to balance the needs of patients, nurses, and the organization, there is a great opportunity for the academe and practice to work together and benefit from the experience (Wonder, & York, 2017).

Currently, healthcare organizations and academic settings have been challenged to develop models for fostering an EBP environment to improve patient care quality (Oh et al., 2009). Effective models for the transfer of new knowledge and research into nursing practice are needed to close the gap between what nurses know and how nurses practice (Baumbusch et al., 2008). However, Tubbs-Cooley (2013) claimed that there is a limited number of models engaging academic nursing faculty and practice-based researchers and clinicians in research collaborations.

Aim of the paper

This article aims to describe Accelerating Research evidence translation through Dyadic Engagement (ARDE) model, a developing model of EBP implementation, which is grounded on the realities of the local setting where the academician-clinician divide exists. It discusses the central idea of the model that academician-clinician dyadic engagement is crucial in the

implementation of EBP. In this model, the term practice and/or nursing practice is operationally defined as the exercise of nursing duties and responsibilities in a clinical setting. Hence, the term practitioners and nurse practitioners shall be used synonymously with nurse clinicians/clinical nurses which refer to nurses working in a hospital/clinical setting. Likewise, the terms nurse researchers, academicians, and academics shall refer to nurses employed in the academe.

Research Engagement of Nurses

Literature suggests that nurses appreciate the potential importance of research to practice (Deans & Lea, 1997; Sellick et al.,1996; Tisdale et al., 1997; Wells & Baggs, 1994; Wright et al., 1996). However, Hicks (1996) claimed that the substantial increase of nursing research activities is generally attributable to the academicians rather than with bedside nurses. Research studies conducted by bedside nurses barely contributed to the field. Despite the important contribution of academic research in the advancement of nursing knowledge, Wright et al. (1996) claimed that clinical nurses are reluctant to participate in conducting research, more so, do not readily implement research findings in their practice.

Research has shown that bedside nurses do not engage in research or actively utilize it within their practice (Nilsoon Kajermo, Nordtsrom, Krusebrant & Bjorvell, 1998; Penz & Bassendowski, 2006; Parahoo, 2009). Happell (2005) specified various common barriers which included: (1) a perceived lack of autonomy for nursing; (2) insufficient time due to increasing heavy workloads; (3) poor cooperation from other health professionals; (4) lack of interest or other negative attitudes on the part of nurses; (5) inadequacy of knowledge, skill, and confidence relevant to research; and (6) the relative inaccessibility of research. Hence, research studies within the academic arena, on its own, is not sufficient to change practice.

Academician-Clinician Divide

While efforts are in place for bridging the research and clinical practice gap, it is undeniable that the academician-clinician divide exists. The existence of this divide discourages nurses, both employed in the academe or clinical practice, from recognizing that they all have the same goal to develop clinical practice to improve outcomes for consumers (Happell, 2002). The existence of this dichotomy among nurses is attributable to what Happell (2005) claimed that the diverse culture between the academic and clinical world of nurses has not been given so much attention.

Nurse academics will most likely take precedence of the requirements of academia like “publish or perish” over the commitment to practice nursing in a clinical area (Cleary & Walter, 2004). Kielhofner (2005a) agreed to this by claiming that academics work in a world where knowledge is judged by scientific rigor and where the ultimate legitimization of knowledge is publication. The imperative to produce outcomes through publications may signify that the number of published articles has significantly greater importance over its relevance in the clinical area (Happell, 2002).

To nurse clinicians, the academic world is very difficult to grasp. It looms in great contrast to the clinical domain. Nurse clinicians are increasingly faced with the need to become more productive despite a decrease in resources. A high, and seemingly ever-increasing, level of patient acuity and an ongoing shortage of adequately skilled and experienced staff are just two of the factors constantly impacting nurse clinicians (Clinton & Hazelton, 2000). In the face of this environment, it is understandably difficult for the clinician to realistically consider the importance of research in clinical practice. Practitioners exist in a world where knowledge is judged by what it allows them to do and the practical results it generates (Kielhofner, 2005a). The development of an appreciation for the world of nurse academics is even less likely to happen.

Attitudes to research provide one example of the academic - clinician divide. Research is perceived as an academic exercise that was unfamiliar, complicated, and threatening (Zuzelo et al., 2006) to clinicians.

Academicians complain that clinicians do not utilize research in their practice, while clinicians frequently regard academicians as out of touch with the relevance of contemporary clinical practice (Happell, 2002). This is echoed by Kielhofner (2005a) by claiming that academics are expressing concern that practice is trailing far behind scholarship while clinicians complain about theory and research being irrelevant to their day-to-day work.

The gap may stem from the clinician's notion of research evidence being inappropriate for clinical practice. This perception is secondary to researchers dealing with or posing questions having little to no significance to the well-being of clients as perceived by the clinicians (Kielhofner, 2005b). Additionally, EBPs coming from studies in the academe are often limited to disseminations even among academics; yet, practitioners of public health agencies are expected to implement evidence-based policies and services of health promotion for populations experiencing healthcare disparities (Towfighi et al., 2020). With this, Kielhofner (2005a) cited various writers who argued that, rather than de-coupling knowledge generation and knowledge use, these activities should be tied together into a single enterprise.

Evidence-based Practice and Academic-Clinical Practice Partnership

Studies show low evidence-based practice, especially in nursing (Melnyk et al., 2004; Melnyk et al., 2016). Several reasons have been accounted for this issue. Bvumbwe (2016) stated that the deficient number of staff, insufficient EBP knowledge of nurses, and the dearth of resources as well as lack of time are deterrents to improving nursing care with the use of evidence-based knowledge.

Accordingly, nurses need to be well prepared to access the available best evidence to identify, develop, and disseminate the appropriate guidelines and/ or other formats of evidence application. The most effective approach to meeting this crucial need is to develop collaborations among nurse researchers, practicing nurses, and professional organizations (Ahmed, 2010).

Collaboration plays a crucial role between partners who recognize that theory and practice alike are essential and that these are two parts of the same agenda. Partnerships offer opportunities for collaborative research for faculty and clinicians (Bvumbwe, 2016) and are a vital element in the implementation of EBP initiatives (Moch et al., 2015).

Partnership is a complex and sophisticated process that requires formation of alliances between two different organizations who will collaboratively work together towards a common goal (Bridges, 2014; Dobalian et. al, 2014). In the context of the nursing profession, strategic alliances are formed between an academic institution or school of nursing and an inpatient healthcare facility located close to one another (Dobalian et al., 2014). This strategic relationship is created to push for their common interests relevant to practice, education, and research (American Association of Colleges of Nursing [AACN], 1990).

Partnership between academic and clinical practice is an instrument in enhancing nursing education, research, and clinical practice. This dyadic relationship assists nurses to initiate the transformation or advancement of health (Bvumbwe, 2016). It appears to be a promising response to the call for academic nursing to be positioned as a partner in healthcare transformation (AACN, 2016). Goosby and von Zinkernagel (2014) highlighted that academic- clinical partnerships provide an excellent foundation for the delivery of evidence-based health services, promotes focus on EBP, and enhance the learning culture (Schinka et al., 2013; Missal et al., 2010).

The existing literature shows that academic-clinical practice partnerships can increase EBP and bridge the gap between theory and practice (Brown et al., 2006; Dooley & Kirk, 2007; Marsiello & Criscitelli, 2014). Furthermore, this dyadic partnership can result in academia being closely linked to service needs and better practical results (Murray & James, 2012). Through the partnership, connections and commitments are established which in turn serve as a foundation for each partner to stay committed to the partnership, learn from each other's strengths, and become responsive to each other's needs as each offers varied resources and talents (Reynolds et al., 2020).

Researchers in the nursing field expressed affirmative results of academic-clinical practice partnerships or collaborations (Beal, 2012; Frank, 2008; Neubrander et al., 2019; Sadeghnezhad et al., 2018). Yi and his colleagues (2020) further claimed that researchers reported positive outcomes of academic-clinical practice relationships. Accordingly, improved patient outcomes and increased evidence-based care delivery are the direct and indirect outcomes of such partnerships. Harbman et al. (2016) reverberated the same by stating that partnerships are established with the commitment to find solutions to barriers of research integration to clinical practice. Such commitment from each party creates a culture of evidence-based inquiry, innovation, and systems improvement.

Benefits of the Academic-Clinical Practice Dyadic Engagement

Sadeghnezhad et al. (2018) noted that the school and the hospital can both benefit from the academic-clinical practice partnerships. One benefit of the academic-practice dyad collaboration includes the compatibility of research topics with the service challenges. The close relationship between the academic and the service providers helps academics to design research projects toward resolutions of the service challenges. Therefore, research findings become more applied, and evidence-based practice increases (Freundl et al., 2012).

Moreover, this dyadic approach is also beneficial by providing opportunities for (1) staff nurses to improve their skills and develop professionally (DeBourgh, 2012; Marsiello & Criscitelli, 2014; Gursoy, 2020; Sadeghnezhad et al., 2018); (2) capacity building of stake holders both in the academia and clinical practice (Bvumbwe, 2016; Gursoy, 2020; Sadeghnezhad et al., 2018); (3) sharing of resources as it provides a platform to capitalize on the expertise of each other (Bvumbwe, 2016; Gursoy, 2020; Sadeghnezhad et al., 2018; Tubbs-Cooley et al., 2013); (4) professional growth resulting from the development of scholarly products (Bvumbwe, 2016; Gursoy, 2020; Sadeghnezhad et al., 2018; Tubbs-Cooley et al., 2013); (5) increase staff satisfaction (Beal et al., 2012); and (6) increased collaborative opportunities for research or quality improvement projects (Beal et al., 2012; Gursoy, 2020; Sadeghnezhad et al., 2018;).

With the above-mentioned benefits, it is acknowledged that the dyadic involvement of academicians and clinicians in EBP activities paves the way in faster knowledge translation compared to the traditional unidirectional flow. This dyadic engagement can be facilitated when the dyad can create what Senge and Scharmer (2001) describe as "a knowledge-creating system," which is a community of researchers and practitioners working together as part of a "continuous cycle of creating theory, tools, and practical know-how." Consequently, a knowledge-creating system involves three interacting domains of activity: (1) capacity-building; (2) practice innovation, and (3) research (Kielhofner, 2005a). For this to happen, the dyad must be able to find a common ground between the thought processes that typically separate scholars and practitioners (Peloquin & Abreu, 1996). They should come up with effective strategies for orientation, cordial behavior, distinct demarcation of roles, and engagement to ascertain that the partnership is recognized and maintained successfully (Gursoy, 2020). Partnerships are said to be effective if they are founded in mutual trust and respect; shared vision, goals, and commitment; open and continuous communication; and recognized strengths and opportunities (Beal, 2012).

Making the Academician-Clinician Engagement Work

Considering the differences in cultures between the academician and clinician, collaboration between members of different cultures will always be challenging. Therefore, establishing a clear vision, goal, and opportunities is of paramount importance (Gursoy, 2020).

Fruitful collaborations always begin with an assessment of strengths and opportunities individually and collaboratively. From the very start, something valuable must be brought to the partnership by each partner (Beal, 2012). Each partner should at least designate a "champion" who will assist in prioritizing and advocating the activities of the partnership with the end-goal of promoting concrete and immediate impacts in real-life (Towfighi et al., 2020).

With a greater focus on issues relevant to clinical issues as research topics, the collaborative engagement between academicians and clinicians can be enabled. Through this mechanism, the clinician finds his/her value in the partnership from the very beginning, and the academician's confidence that the research topic is relevant and useful also increases. Nonetheless, clinicians are more likely to be interested in clinically relevant issues as they are placed in a position where they are the best person to identify researchable questions than their academic counterparts. Further, clinicians would more likely to perceive themselves as true partners if they are involved in the research process from the very beginning. Consequently, they, more often than not, become active research collaborators and are more likely to become actively involved in introducing the findings into practice since they see the relevance and benefits of the findings produced (Happell, 2005).

Meanwhile, Happell (2005) also suggested that the collaboration can extend beyond the conduct and implementation of findings from the collaborative research. Academicians can encourage and/or assist the clinicians to present and/or co-present their findings at professional conferences and eventually become co-authors of published manuscripts. With the nature of the academe, academicians are more well-versed in the publication process; thus, they are more inclined to overcoming the barriers to publication. Any efforts to publication by the dyad must be viewed as a positive development in advancing the nursing profession as a whole. As numerous publication articles become more clinically relevant, more clinicians will be encouraged to read professional and scientific journals.

Likewise, nurse academics are more probably to find the value of maintaining a strong link with their clinician counterparts. Since engaging in research is an integral part of nurse academics' role, maintaining an open and sustainable connection with clinicians is essential so that his/her knowledge and skills remain contemporary. Moreover, outcomes of collaborative efforts delving into clinically relevant issues are more likely to be translated into clinical practice. Thus, both academicians and clinicians can know their mutual goal of developing clinical practice to improve client outcomes (Happell, 2005).

Accelerating Research evidence translation through Dyadic Engagement (ARDE) Model

The ARDE Model was derived/developed from a prior study on EBP. This model was inductively based on local studies of Arde (2018) and Lumanlan (2018) on EBP and critical reviews of existing literature on Academic-Practice Partnership in the health-related professions such as nursing, medicine, pharmacy, social work, and occupational therapy. It was heavily informed and inspired by the Advancing Research and clinical practice through Close Collaboration (ARCC) Model developed by Melnyk and Fineout-Overholt (2010) and the Scholarship of Practice by Kielhofner (2005a).

The ARCC Model proposed that a culture of EBP that includes mentors with advanced knowledge of EBP, mentorship, and individual, as well as organizational change, is necessary to advance and sustain individuals' and healthcare systems' evidence-based care (Melnyk & Fineout-Overholt, 2010). The Scholarship of Practice, on the other hand, assumes that the end-user of knowledge must be part of its generation. Knowledge generation should emerge from the cooperation

between those who play the role of knowledge-generators and those involved in knowledge application. Thus, it magnifies the collaborative efforts of scholars and practitioners working as partners in advancing knowledge and practice simultaneously.

Overview of the ARDE Model

The ARDE Model is a context-based paradigm that features the academician-clinician dyad in EBP implementation. The term dyadic engagement was coined referring to the academician and clinician (known as the dyad) actively engaged as partners in EBP initiatives.

This model was conceptualized capitalizing on the fact that majority of staff nurses are seeking out relevant knowledge using other EBP information sources that are more accessible to them such as journals, books, and most especially, peers. This situation is related to the sad reality that, at present, EBP knowledgeable colleagues are absent in the clinical practice setting who will mentor or model the EBP process. Thus, clinicians oftentimes consult their colleagues in the academe. This consultation lies in the assumption that nurse academicians are more research-oriented and are more adept at the concept of EBP. Thus, they are up-to-date on the latest trend in nursing practice. This instance corroborates the study of Breckenridge-Sproat et al. (2015), whereby their respondents frequently identified nurse educators and advanced practice nurses as mentors who facilitate or support EBP.

Partnerships are crucial for the implementation of EBP initiatives (de Cordova et al., 2008; Missal, Schafer, Halm, & Schaffer, 2010). EBP collaboration allows the sharing of resources and expertise. Working together has enhanced skills in teaching and enculturating EBP in academia and the hospital (Basol, Larsen, Simones, & Wilson, 2017).

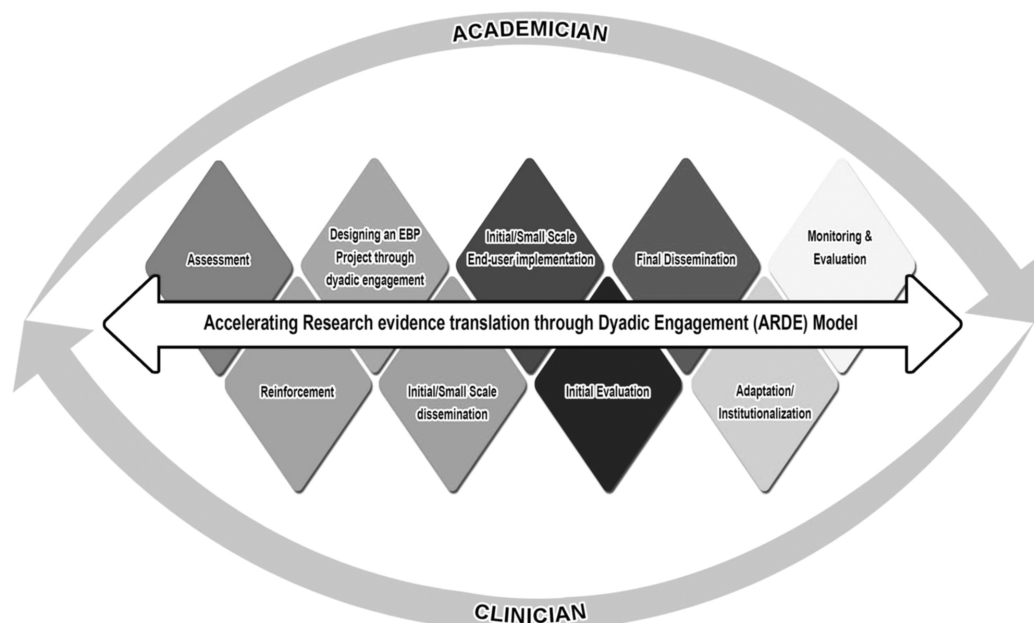
Clinicians, according to the IOM (2012), often lack access to relevant information promptly. Therefore, faculties (academicians) are uniquely positioned to lead EBP projects with clinical agencies such as hospitals, long-term care facilities, clinics, community care management organizations, and health departments (Moch et al., 2015). This dyadic engagement between the academician-clinician provides an opportunity to learn together, discuss EBP and its implementation. The dyadic engagement facilitates efficient research translation to practice, enhances the quality of care, and promotes positive change.

Purpose of the Model

The premier purpose of this model is to provide healthcare institutions with a pragmatic guide for a successful implementation of EBP in nursing with consideration of different work cultures. Secondly, it was developed to augment what Tubbs-Cooley's (2013) claim regarding limited models of dyadic engagement among academicians and clinicians in collaborative research.

Figure 1. ARDE

The figure represents the continuous series of steps needed to implement EBP. The multi-colored diamond symbols containing the different steps of the implementation procedure represent the complex but fun process with the ultimate aim of creating a life to a new practice. The double edge arrow represents the implementation of the continuum. These aspects are encapsulated by a continuous arrow representing the dyadic engagement of the academician and the clinician.



Operational Definition of Terms

The ARDE Model is comprised of key concepts that are low in abstraction, however some unique meanings are ascribed to these concepts, thereby reinforcing the need for their operational definitions.

- **Assessment** is the process by which individual and organizational strengths and weaknesses are determined. The results of the assessment shall serve as the bases of reinforcement strategies.
- **Reinforcement** is the process wherein strategies are implemented so that individuals in particular and the organization in general, are strengthened which leads to greater chances of implementing EBP.
- **Dyadic Engagement** is the partnership between an academician and a clinician to solve a clinical problem of common interest. It is the complementary sharing of expertise (research skill of the academician and practice skill of the clinician) through interaction that directs consensus response to the mutually-identified clinical problem.
    - **Academician** is an EBP-expert nurse faculty who has the necessary research skills.
    - **Clinician** is an EBP-advocate practitioner who is trusted and admired by his/her colleagues because of exemplary practice skills.
- **Initial/Small scale dissemination** is the process by which results of the collaborative research is presented to key players of the organization and initial adopters of the new practice.
- **Initial/Small Scale End-user Implementation** is the process wherein the new practice is applied by initial adopters that would serve as a pilot test.
- **Initial Evaluation** is the process of assessing the pilot test of the recommended new practice. Findings shall be the foundation of necessary modification on the recommended practice.
- **Final/institution-wide Dissemination** is the process by which results, findings, and output of the initiative undertaken by the dyad are shared and communicated to all adopters in the institution.
- **Adaptation/institutionalization** is the process by which new practice is embedded in the organizational system and used as a standard in the delivery of care.
- **Monitoring and Evaluation** is the process wherein implementation of the new practice is continuously reassessed for modification or refinement.

Description of the ARDE Model

Assessment. To achieve better chances of EBP implementation, assessment of individual and organizational strengths and weaknesses is very essential. Through this, barriers and facilitators of collaborative engagement are determined. Assessment results are a significant basis in determining of areas of concern/s, individual and organizational needs, and opportunity for intervention and capacity-building. They are foundational elements in reinforcement strategies.

Reinforcement. This stage aims to address, strengthen, and/or enhance the different aspects determined in the assessment stage.

At the organizational level, this stage aims to formalize the partnership. Having a formalized agreement in place is important to help navigate challenges and celebrate successes. A formal memorandum of understanding (MOU) is important to articulate and formalize the collaborative relationship. The MOU would specify the role of each partner in collaboration on projects and what type of communication needs to occur to successfully reinforce EBP skills.

At the individual level, facilitating learners to learn about EBP, build skills in EBP, and assisting them to move beyond the status quo is the role of a faculty EBP mentor (Fineout-Overholt, & Johnston, 2006). Proper methodologies are employed by the EBP trainer/expert to attract the target audience in committing fully to EBP implementation. Additionally, this stage is an opportune time for capacity building which boosts the provider's abilities and commitment to using research evidence in their practice. Capacity-building aims to enhance local stakeholders' awareness and capabilities both as individuals and collectively (Kielhofner, 2005a). This can be achieved through technical assistance, training programs, information sharing, technology transfer, materials development, and funding that enable an organization to better serve customers or to operate in a more comprehensive, responsive, and effective manner (Center for Disease Control and Prevention, 2001).

However, issues on whether it is possible to train every nurse to be at the expert level needs to be addressed at this stage. The ARDE model believes that all nurses might not reach the expert level (Enskär, 2012) but it contends that every nurse should become aware and appreciate the value of EBP as a standard of care. This contention is supported by the fact that fewer nurses are engaged in research activities after leaving nursing school. Studies have shown that most nurses utilize knowledge from various sources such as literatures, education, colleagues, guidance of experts, but seldom use research evidence. (Berland, Gundersen, & Bentsen, 2012; Dalheim, Harthug, Nilsen, & Nortvedt, 2012). Thus, Ciliska (2006) suggested that clinicians should have a basic understanding of the purpose and EBP process, have the competency to ask relevant clinical questions, and know who in his/her work setting can provide help in answering questions. It is crucial for the entire staff to be aware

of EBP and mindful of reflection in practice, as well as having the ability to ask questions. It is the clinician who has better knowledge of the practice area, and who are in direct contact with the patient. Therefore, to address this issue, this stage aims to identify potential EBP leaders as change mediator/agent in the practice setting. Identifying and supporting champions will begin to prepare the organization for the change.

Clinicians who are identified as change mediator/agent in the practice setting shall be paired with an EBP expert in the academe, who share common interests. They will be forming the academician-clinician dyad.

Designing an EBP Project through dyadic engagement. According to Fineout-Overholt and Johnston (2006) when EBP is non-existent, a partnership is required between (nurse) scientists/researchers/academician who can assist with methodological rigor, and clinicians who provide the question, context, and implications for research translation into clinical practice.

In this stage the academician-clinician dyad sharing the same interest shall work as partners in an EBP Project. The dyad shall bring into the dyadic engagement their expertise and share their resources. Academicians (research expert) and clinicians (clinical practice experts) are expected to collaborate on research initiatives on clinically relevant issues that would generate new knowledge to advance the nursing discipline in general. They are expected to improve nursing practice through evidence-based strategies.

This dyadic engagement underscores that both appreciate each other's expertise and that combined and separate responsibilities exist and are recognized. Academics and the community members (clinicians) with whom they form a partnership may take turns filling roles such as coach, educator, or technical assistant (Kielhofner, 2005a). The differing lines of expertise converge to design an EBP project of common interest. The clinician provides the practice focus and clinical context essential in bridging the gap in nursing practice whereas the academician offers the research skills to guarantee valid and reliable results. Both are actively and equally involved in all stages of the EBP process, overall project design and the establishment of the implementation and evaluation plan. Their formulated plan of action or clinical guidelines shall be presented and disseminated to their target adopters.

Initial/Small scale dissemination. This stage involves the dyad (now known as the EBP proponents), the organizational committee that approves or rejects implementation, and the initial adopter. This stage aims to persuade the group to try the suggested practice for a pilot study. At this stage, findings generated from dyadic engagement are communicated and the comparison between "what is being done" and "what should be done" is presented. This is an initial effort to obtain organizational buy-in and be able to ascertain initial adopters.

Initial/Small Scale End-user Implementation. This stage involves the initial adopter and the EBP proponents who will pilot test the new practice. Piloting/trying the new practice is conducted to evaluate the feasibility of the new intervention as it allows an allowance for improvement before adaptation or institutionalization.

Initial Evaluation. The initial evaluation aims to assess the conduct of the pilot study. Pitfalls are determined and shall serve as a basis for modification and fine-tuning of the initial implementation plan. The initial evaluation is tedious in that it tries to resolve multi-factorial issues of the initial implementation. This stage also opts to find out organizational barriers that would impede the smooth implementation of the new intervention.

Final Dissemination. Refined and/or final implementation plan based on the initial evaluation shall undergo in this stage. In the final dissemination, it is an organization-wide phase involving inter-professional leaders and the people involved during the initial dissemination. This mass dissemination aims to convince the organization/institution to adapt or institutionalize this new practice, with the pilot study serving as an exemplar of successful implementation.

The initial adopters are expected to influence other members of the organization to use the evidence-based practice. Their testimonies will emphasize how the new practice has become beneficial to them and their unit with the aim of wider buy-in within the organization. More so, organizational leaders will decide as to whether the new practice will be adopted or rejected. Once rejected, the new practice may still be modified incorporating the recommendations of the committee and contextual barriers until no further refinement is needed, and consequently approved for adaptation and institutionalization.

Adaptation/Institutionalization. At this stage, the accepted new practice for institutionalization will be adopted as proposed by the dyad and will become the standard of care for the entire organization. As the new intervention has become an integral and sustained part of the organizational system, the translation of new knowledge to support practice is said to be complete and successful.

Monitoring & Evaluation. According to the Canterbury District Health Board (2006) evaluation is the assessment of both processes and outcomes of a program or implementation. Even if the new practice is adapted and institutionalized, it shall be monitored for progress and documentation. Constant evaluation is a safety net that nursing care being delivered is comparable to

international standards making the nursing profession not only a service-oriented profession but also a profession responsive to the needs of the times.

Limitations of the Model

The model is not without weaknesses. A foreseen weakness of the model is the absence of measures/tools specially designed to measure the concepts. Although the existing literature contains instruments to measure the concepts, it would be necessary for the model to come up with an instrument unique to it.

Implications to Nursing Practice

The ARDE Model makes a significant input to nursing knowledge for various reasons. First, it was specially designed in the Philippine context where EBP implementation is slow-moving. Secondly, it highlights the importance of partnership between academicians and clinicians who express the same zeal to EBP as a standard of care. Collaborative practices between two individuals of divergent expertise provide a timely translation of evidence to practice by making sure that the proposed guidelines/recommendations are mutually created with inputs of different perspectives.

Both the nursing academe and practice can benefit from this model in several ways. Since research output and utilization of research findings are part and parcel of the functions of both parties, the model is a safeguard such that nurses are continuously engaged in research activities and those research-driven findings are utilized by target populations. For the nursing academe, the results of the joint EBP investigation can be shared with students to boost and nurture their interest in EBP. In nursing practice, the model can help in keeping updated healthcare interventions, context-relevant policies, and promotion of continuing professional education.

With the application of the ARDE model, the healthcare organizations are assured that EBP is fostered. Stakeholders are guaranteed that the care being delivered by the nurses are continuously reviewed and improved. The application of the model supports the relevance of nursing as a profession and of nurses as valuable members of the healthcare team and as critical partners in health development. Lastly, the model protects the image of the profession by making sure that care is delivered in an evidence-based way.

ARDE Model as a New Way Forward

In a context where the academician-clinician divide exists, finding strategies to merge the two is crucial for EBP to take place. Knowledge translation models that highlight strong engagement between academics and clinicians will pave the way for the implementation of such practice. Academic-clinical practice partnership can be a vital mechanism in the advancement of evidence-based decision making and the implementation of evidence-based programs and policies (Erwin et al., 2019). Hence, the ARDE model offers one promising approach in facilitating EBP implementation in a local nursing setting where the division of nurses is apparent. The powerful dyadic engagement that the model emphasizes is an important mechanism in bringing closer together the different cultures of academicians and clinicians as they work together in solving clinical issues. This partnership that fosters collaboration and sharing of expertise and resources can be an assurance in the simultaneous advancement of the knowledge and practice of the nursing profession through EBP initiatives.

A perceived strength of the proposed model is the academician-clinician dyad that collaborates in the conduct of EBP initiatives and its implementation. Their unique partnership requires the individual expertise of the dyad to cover different aspects of the EBP implementation. As the dyad comes from different cultures, they provide differing knowledge and skills which supplement the "shortcomings" of each of the dyad. Another perceived strength is the explicit inclusion of the Evaluation process as the last stage of the EBP implementation. According to Fineout-Overholt and Johnston (2007), evaluation as a process of EBP has been fairly well-documented. They underscored that existing literature has dealt so much in the initial steps of the EBP process but less information has been provided on the last step which is Evaluation. Therefore, the model contends that continuous evaluation should still be done to ascertain sustainability and to address the dynamic nature of healthcare.

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"Nurses are the backbone of any health system. Today, many nurses find themselves on the frontline in the battle against COVID-19."

-- **Dr. Tedros Adhanom Ghebreyesus, WHO Director General**