Alberta Health Services
Critical Care Strategic Clinical Network™

Critical Care Strategic Clinical Network
Provincial Delirium Initiative

Sustainability Planning Tool

Intensive Care Unit: _____

Name of documenting team member: _____

Please Note: the team member selected to document is responsible for taking this sustainability planner back to the ICU and completing the planner in collaboration with your implementation team members. The CC SCN Delirium Practice leads will follow up to support you with this planning.

This tool was adapted from Health Quality Ontario's Sustainability Planner.

Last Revision Date (2018-Aug)

CC SCN Provincial Delirium Initiative
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QSO mandated organizational priority:

On March 29, 2018, the Quality, Safety & Outcomes Improvement Executive Committee (QSO) of Alberta Health Services, comprising Executive Leadership Team members, and Zone Medical and Operational leaders, approved the Provincial Delirium Initiative as a quality improvement priority for the organization for 2018/19.

- **What does this mean for you?**
  - Your input is being heard and recognized since critical care staff and patients and families identified ICU delirium as a concern as part of CC SCN's Evidence Care Gap research.
  - All organizational priorities for 2018/19 were reviewed in this prioritization process. Endorsement by QSO members, and in turn, ELT means acknowledgement of the importance of implementing and adopting ICU delirium-related best practices on patient experience, patient outcomes, and improved efficiencies.
  - Your ICU leaders will continue to support you with this ongoing quality improvement work.
- **What are the expectations from your ICU?**
  - As a result of endorsing the Provincial Delirium Initiative as an organizational priority, QSO members require ongoing progress reports and plans for sustaining the gains made by this improvement initiative.
  - Routine audit of unit-specific data.
  - Routine review of Plan, Do, Study, Act (PDSA) cycles and unit-specific data at implementation team meetings and/or unit/site quality council meetings.
- **How will the CC SCN continue to support this work beyond project funding end date (Sept. 2018)?**
  - The CC SCN will continue to provide routine audit and feedback reports to unit, zone and provincial leaders.
  - Coordinate collaborative learning opportunities, such webinars.
  - Coordinate networking opportunities across the province.
  - Facilitate the incorporation of approved ICU Delirium tools and templates into Connect Care.
  - Provide progress reports to QSO Executive Committee.
  - Assess and report on value and return on investment.

Definition of sustainability:

- Sustainability means embedding a successful improvement idea that has been trialed in a PDSA cycle into the culture and norms of the ICU/facility.
- Sustainability ensures gains are maintained beyond the life of the project.
- Sustainability is the routinization of processes into ongoing organizational systems until the process becomes business as usual and can be sustained without concentrated maintenance efforts, and in turn, ensure continuous high-quality care and reliable safe practices.

Objective of this sustainability planning tool:

An important part of the improvement journey is planning how you are going to sustain your improvement efforts. The beneficial results of an improvement project have been sustained when the new ways of working have become the norm, or when things have not returned to the old way of doing things after a year.

The objective of the Provincial Delirium Initiative Sustainability Planner is to encourage you, ICU Implementation Team members, to think about the seven key factors that will help sustain the improvements that you have made. These seven factors are:

1. Clarify what you are sustaining
2. Engage leaders
3. Involve and support front-line staff
4. Communicate the benefits of the improved process
5. Ensure the change strategy has been trialed, and is ready to be fully implemented and sustained

6. Embed the improved process
7. Build in ongoing measurement

The seven key factors for success are discussed below. For each factor, a set of considerations has been listed, as has a small area for your team to plan your next steps. The more considerations you assign responsibility for and accomplish, the higher the chances of sustainability.

Documents included in Appendix:

A. Unit & provincial data
B. Unit-specific Scorecard
C. List of Implemented Change Strategies – examples of strategies that each ICU has implemented.
D. Upcoming collaborative learning webinar topics
E. CC SCN: Available Resources, Tools and Templates

1. Clarify what you are sustaining

It is necessary that the entire team agrees upon what is being sustained. Is your team planning on sustaining a specific change practice, such as compliance with pain assessment every four hours (ie. process measure)? Or, is the team trying to sustain a change concept, such as reducing incidence of delirium through a number of different change ideas?

We are planning to sustain:

Actions:

1. Review the "List of Implemented Change Strategies" document in appendix/team package and ensure it accurately reflects the strategies you have implemented in your ICU. Use the space below to list additional strategies that are not reflected on the "List of Implemented Change Strategies." Only one metric will be used for discussion for the remainder of the activity.
2. Review your Unite Score Card and assess where you currently are in relation to your targets. Your current state will give you an idea of your gains to date. Take this into consideration for the discussions in the following six sections.
3. Select one of the metrics below that you would like to focus on for sustaining the work done to date. For team discussions in Sections 2 to 7, consider the specific strategies/practices that have been implemented in your ICU in order to achieve your target goal for the chosen metric.
4. Consider the resources and tools that are currently available as listed on the "CC SCN: Available Resources, Tools and Templates" as you plan your next steps.

Provincial Mandatory Metrics (i.e. Change idea or change concept):	**We are planning to sustain the following list of specific strategies/practices that have been implemented in our ICU in order to achieve our target goal for each metric:**
% compliance with Q4hr documented pain assessment.	
% of pain assessment where patients are in significant pain.	
% of patients eligible for “out of bed” mobility who received “out of bed” mobility in 24 hours.	
% compliance with Q-shift documented delirium screening.	
Average % compliance time with RASS assessment.	
Currently chosen unit-specific metrics (indicate your unit-specific metric; refer to your scorecard in the appendix if needed):	**We are planning to sustain the following list of specific strategies/practices that have been implemented in order to achieve our target goal for each metric:**

2. Engage leaders

Support of organizational leadership is essential to successful quality improvement work. Clinical and administrative leaders who work directly on, or indirectly support, the improvement project must ensure that all barriers to success are removed and project priorities are clearly identified and communicated.

Think about who needs to be on-side for changes to happen. Think about who ultimately influences whether or not something happens – these are the leaders within your unit/department. At the ICU level, the leaders may be everyone who works in the ICU (e.g., physicians/NPs, CNEs, UM/PCM, RN lead, RT lead).

Considerations for ensuring sustainability:	Next Steps
☐ A physician champion (physician and/or NP), has been identified. ☐ The physician champion has devoted time to participate as a member of the improvement team. ☐ A team lead has been identified to ensure the team has regular meetings, and to hold others accountable for accomplishing action items/deliverables. ☐ The Patient Care Manager supports the improvement initiative. ☐ The operational leader (UM or PCM) is accessible and has removed barriers or threats to facilitate process improvement. ☐ The physician champion or ICU Medical Director is accessible and has removed barriers or threats to facilitate process improvement. ☐ All leaders (ie. Implementation Team members, CNE, CNS, UM, PCM, physician champion) in your unit are able to clearly articulate the benefits of the improvement strategy or best practice, such as: importance of early mobility for positive patient outcome; or appropriate pain management for improved patient experience; or education session for improving staff knowledge/skills.	To strengthen leadership engagement, we will:

3. Involve and support front-line staff

Front-line staff members play an important role throughout every quality improvement initiative. In the early phases of a project, they may be involved in identifying problem areas and solutions to test. Later, they may be involved in identifying training needs and delivering / receiving training themselves. Continual support and evaluation of the needs of those working within changed processes is necessary to ensure that changes are sustained.

Considerations for ensuring sustainability:	Next Steps
☐ Staff members were provided with information about the purpose and significance of the practice change. ☐ Front-line staff helped to identify issues from their perspective. ☐ Front-line staff members have been involved in developing solutions. ☐ The 'right' (most appropriate or qualified) staff are involved in the improvement work (ex. CNEs, informal frontline staff leaders/influencers, those who 'believe'/value the importance of this improvement work, RT leads, Allied health representation, pharmacist) ☐ Methods to regularly communicate (ie. updates, progress, and next steps) with staff other than those directly working on the improvement team have been identified and used. • What regular method is currently used? _____ • Has this method been effective? _____ ☐ A plan to address training needs has been created.	To strengthen the involvement of front-line staff, we will:

4. Communicate the benefits of the improved process

Changes should address the root causes of problems and produce measurable benefits that meet the needs of all stakeholders (i.e., patients, front-line staff, providers, and leaders). Each stakeholder should be able to determine what benefits the changes bring to him or her.

Considerations for ensuring sustainability:	Next Steps:
☐ Benefits (to patients, families, and staff) of adopting the new process or practice have been communicated to front-line staff. ☐ Success stories, positive patient stories, and updates about this improvement initiative are regularly shared at staff meetings, in staff newsletters and/or on unit quality boards.	To communicate the benefits of change, we will:

5. Ensure the change is ready to be implemented and sustained by testing in PDSA cycles

It is important to ensure that the change idea is effective and beneficial before moving to the full implementation phase. Effectiveness is determined by testing in PDSA cycles before full implementation. Many practices have expended a great deal of energy and time on the implementation of change ideas that did not improve quality or streamline processes.

Considerations for ensuring sustainability:	Next steps
☐ The change has been tested in PDSA cycles and preferably in a variety of conditions. ☐ The PDSA cycle audits or project measures are demonstrating real improvement. ☐ The changes have improved efficiency or made jobs easier (reduced waste, avoided duplication, made things run smoother).	To ensure the change is ready to be implemented and sustained, we will:

6. Embed the improved process

A common barrier to sustainability is not linking the goal of the new process or practice to the overall vision of the improvement initiative or vision of the unit (ie. Best care for critically ill Albertans). Without this link, it is often difficult for people to determine why valuable resources are being allocated to the improvement project.

Considerations for ensuring sustainability:	Next Steps
☐ The best practice being implemented improves patient care or decreases risks to patients, and contributes to the continued success of the ICU in providing best care to critically ill Albertans. ☐ Training has been provided to front-line staff about the improved processes and changes so they know what is expected of them (ie. training about the Readiness to Mobilize assessment tool). ☐ Unit procedures have been updated or created to reflect the new processes. ☐ The new processes are now “standard work” and supported with forms, checklists, reminders (visual cues), and technology (eCritical Metavision or Tracer). ☐ The team has a mechanism for discussing, examining and adapting the improved processes (ie. Implementation team meetings, Quality Council meetings, physician meetings).	To embed the improved process and make it the new standard, we will:

7. Build in ongoing measurement

Establishing an ongoing measurement system and a standardized way of communicating results reinforces that the change is important to the practice. A mechanism for looking at a few key and relatively easy to extract measures allows teams to see if there is slippage and to take action to resolve any issues. It also allows teams to celebrate when an indicator has stayed at an improved level over time.

Considerations for ensuring sustainability:	Next Steps
☐ The leaders in the ICU responsible for this improvement initiative (ie. Implementation team members) are skilled in quality improvement (ie. understand PDSA cycles or Driver diagrams). ☐ Unit Implementation Team or quality council has selected or identified a refined set of measures to track on an ongoing basis (ie. unit specific metrics on your unit scorecard). ☐ Implementation Team members are aware of ICU Delirium Provincial Framework. The ICU Delirium Provincial Framework identifies a refined set of measures for each clinical practice expectation. The framework is evidence-based, applicable to Alberta, and vetted across the province. ☐ Will the chosen measure(s) provide the necessary information for sustaining improvement? (For example, if your team is sustaining improvements in appropriate pain management, the suggested measures to track are compliance with Q4hr pain assessment and patient-reported pain scores.) ☐ A person has been assigned responsibility to review, print, and share related eCritical Tracer reports in Tableau. • Name of staff member responsible for above task: _____ ☐ Manual audits: for unit-chosen metrics where eCritical data reports are not available, the data for the measures is being collected regularly. • Name of staff member responsible for manual audits: _____ ☐ There is a structure or mechanism in place for reviewing the measures on a regular basis. ☐ There is a plan for communicating performance to front-line staff, providers, and leaders within the practice. ☐ There is a plan to outline what we will do to reflect on our progress – to celebrate continued success and to respond if our measures start to slip. ☐ Celebrate accomplishments and aspire to take performance to a new level.	To strengthen our capacity for ongoing measurement, we will:

Helpful Sources

- Centre for Healthcare Quality Improvement (2010). *Sustainability Planning: A Guide for ED-PIP Coaches & Team Leads*. CHQI: Toronto, Ontario.
- NHS Modernization Agency (2002). *Improvement leader's guide to sustainability and spread*. Ancient House Printing Group: Ipswich, England.
- Maher, Lynn, Gustafson, D. and Evans, A. (2007). *NHS Sustainability: Model and Guide.* NHS Institute for Innovation and Improvement: England.

Appendix A: Unit & provincial data

Appendix B: Unit-specific Scorecard

Appendix C: List of Implemented Change Strategies – examples of strategies that each ICU has implemented.

Zone	Unit	Unit metrics	Change Strategy
South Zone	CRH	• →mobility discussed daily • →% of compliance of Q4hr RASS assessment	• Tea time • RASS assessment education
	MHRH	• % of time goal RASS discussed daily • Unit specific sedation management guideline is developed	• iRounds Board checklist incorporated • Sedation Mgmt. Protocol • RASS assess compliance
Calgary Zone	FMC ICU	• % time target RASS ordered and documented daily • mobility discussed daily	• Rounds Checklist • Delirium family Pamphlet • Mobility care plan • PT role • Target RASS order • Day/Night Routine guideline • Resident teaching • cognitive boxes
	PLC	• Mobility discussed daily • Unit specific mobility protocol/guideline is established	• Mobility Mobility education days Move-it or lose-it • Extubation Rounds physician meetings 1:1 • Mobility Demonstrations
	RGH	• mobility discussed daily • % of patients with a q12hr mobility assessment completed	• Mobility Readiness assessment q12hr • Sleep day/night routine
	SHC	• % of time targeted sedation and goal RASS ordered & documented daily • % of time pain mgmt. is discussed daily	• Bullet Rounds • OT in ICU • Target RASS discussion
	FMC CVICU	• % of time Target RASS discussed at rounds • % of time target RASS is documented daily	• Mobility Guideline CVICU • Target RASS

Zone	Unit	Unit metrics	Change Strategy
Edmonton Zone	GNH	• mobility discussed daily • Unit specific sedation management guideline developed • NEW: percentage of time SAT screening is completed on an intubated patient. • NEW: percentage of time SBT screening is completed on an intubated patient.	• SBT protocol • mobility: PT consistency of education
	MIS ICU	• mobility discussed daily • % of patients assessed for SBTs documented daily	• Target RASS ordering on rounds • mobility: readiness tool • cognitive stimulation: brain mobility • whiteboard use & quality board
	U of A GSICU	• % of time RASS assessed and documented q4h • % of patients on a continuous analgesic and sedative infusion	• pain and agitation teaching with ICU resident staff (by MDs to MDs) • communicating daily goals via whiteboards • cognitive stimulation: brain mobility • survey staff re: mobility barriers • improving rounds communication about scoring tools (language ICDSC vs delirium score)
	RAH	• % of time RASS assessed and documented q4h • SBT eligibility assessed and documented daily on all ventilated patients	• Pain and agitation teaching in annual recertification days • new SBT guideline & roll-out • mobility readiness tool • sleep promotion strategies
	U of A Neuro	• mobility discussed daily • new: % of Patients Eligible for SAT/SBT	• mobility readiness • SBT eligibility in Neuro population • PT/OT role in mobility Pharmacist role in pain discussion on rounds

	MAZ CVICU	• % of ICDSC completed for eligible patients • % of patients who get 4 or more hours of consecutive sleep • Unit specific pain & sedation management guideline established	• staff-led education & teaching • in the works - working with GSICU on this
	SCH	• Unit specific guideline for SBTs developed and followed • # of pts eligible for SBTs • *new metric: restraint use #hours patients restrained (% • sleep hours (need to clarify which metric for scorecard)	• mobility discussion in rounds • sleep hygiene • PT role/RN role in mobilization • restraint use & delirium • SAT & SBT eligibility

Zone	Unit	Unit metrics	Change Strategy
North Zone	QE II	• mobility discussed daily • Unit specific delirium prevention & management guideline developed • %pts eligible for SAT & receive SBT	• RT led evening rounds to promote discussion about SBTs, Mobility Readiness tool, focus on SAT & SBT eligibility, communication whiteboards in each pt room, pharmacy involvement on rounds for prn pain mgmt
	NLRH	• Staff Knowledge • Compliance RASS assessment SBT	• Bullet Rounds SBT Protocol Staff Knowledge survey
Central Zone	RDRH	• mobility discussed daily • Unit specific mobility guideline/protocol developed	• Mobility Guideline • Rounds & report Script Sounds Ears

Pediatric Units	ACH	• % patients with documented q4h sedation score (SBS) and % delirium assessments completed & documented (CAPD)	• Both teams have focused on staff education as delirium awareness is fairly new. Education on pain and delirium screening tools, withdrawal assessments & importance of early detection of delirium. Both teams also streamlined the early mobilization guideline to create a provincial document and new documentation in MetaVision to support changes. Extubation Readiness Trial guidelines also developed with corresponding charting changes in MV.
	Stollery PCICU	• % of patients with documented q4h sedation score (SBS) and delirium screening compliance	
	Stollery PICU		

Appendix D: Upcoming collaborative learning webinar topics

- **Noise Reduction in the ICU by Dr. Gonzalo Guerra**
- **My Health Alberta, Delirium page by Heather & Michelle**
- **All behavior has meaning; Delirium versus Dementia by Mollie Cole**
- **Small strategies = Big Change by Jeanna & Heather**
- **Pain Management for the critically ill patient**
- **Sustaining your work- CCSCN**
- **Extubation Rounds- Learnings from the PLC team**
- **Sleep Strategies & Day/Night Routine**
- **Accessing your Delirium Data Report- by eCritical**

Appendix E: CC SCN: Available Resources, Tools and Templates

Engage Leaders	•Regular communication with PCMs, Medical Directors, Executive Directors, and Zone Leaders •Audit & feedback reports provided to leadership team
Involve & support frontline staff	•ICU Delirium Provincial Framework •Delirium content in OPACCA •CKCM: ICU Delirium toolkit & order sets informed by this initiative •Metavision charting forms in eCritical (ex. ERT, mobility assessment) •Delirium content videos on ICU Delirium AHS website •ICU Delirium content on MyHealth Alberta website •ICU delirium related webinars
Communicate benefits of improved process	•Newsletters •Provincial audit and feedback reports •Provincial success stories & highlights •Provincial posters •Return on investment & impact assessments •ICU Delirium AHS website
Embed improved process	•forms in eCritical Metavision •support incorporation of ICU delirium content into Connect Care
Build in on-going measurement	•eCritical Tracer reports •Provincail audit and feedback reports •ICU Delirium Provincial Framework with metrics and targets