

Learning from the IC5 Collaborative Experience

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PREFACE

The IC 5 Collaborative Project (*IC 5: Improving Continence Care in Complex Continuing Care*) was the first multi-hospital quality improvement project conducted by the Hospital Report Research Collaborative (HRRC) aimed at the Complex Continuing Care sector. Findings from *Hospital Report 2003: Complex Continuing Care* showed that there were variations in processes and outcomes in continence care across Ontario (e.g. utilization of indwelling catheters and worsening of urinary incontinence) that supported continence care as a critical improvement opportunity.

Utilizing a quality improvement collaborative methodology entitled the “Breakthrough Series” developed by the Institute for Health Care Improvement (IHI), 12 teams from various hospitals across Ontario worked together for 10 months under the guidance of quality improvement consultants and content experts in continence care. The project was carried out by the University of Toronto IC 5 research team comprised of principal investigators, clinical and improvement experts, coaches, and a project manager, who supported teams from the 12 participating organizations.

As a corollary to the IC 5 Collaborative Project, research was conducted to evaluate the effectiveness of the quality improvement methodology. The formal evaluation examined the uptake and impact of the IC 5 Project on continence care processes and outcomes within participating hospitals in a quest to ultimately determine the effectiveness of the quality improvement methodology.

Finally, in order to gain a richer understanding and learn more about the IC 5 experience, interviews were conducted with a sample of the IC 5 participants and the three IC 5 coaches. The interviews were conducted by Anu Macintosh-Murray, a qualitative researcher with many years of experience in the field of quality improvement. The following shares the learnings from the IC 5 Collaborative Project Experience.

Sonya Pak, IC 5 Project Manager

EXECUTIVE SUMMARY

Summary of Discussion Points

The following is a summary of key learnings from the interviews, abstracted and reproduced from the main sections of the report. Most are presented as discussion points to consider when planning an improvement collaborative project.

1) Overall benefits of the IC5 Project:

Key elements that participants valued very highly include

- access to the expertise and resources (clinical and improvement),
- contact with the coaches,
- learning the rapid cycle methodology,
- opportunities to share experiences with peers and to build networks,
- structure provided by the collaborative (to help keep them going), and
- recognition and celebration.

2) Clarity of expectations

Discussion point:

- What is needed to ensure that communications about project requirements are received and understood by the organizations and that appropriate planning takes place prior to committing to a collaborative? Organizations would benefit from a frank self-appraisal of both their capacity to take on yet another project and their improvement capabilities, to make sure they can provide the support that teams require.

3) Team composition

Discussion points:

- There are a range of factors that must be considered when initially organizing the improvement teams:
 - Whether to have an intact team or a team with members pulled from various parts of the organization

- The need to include
 - front line staff who know the care processes
 - both allied health and nursing staff
 - individuals who are enthusiastic, have clinical credibility, and can act as champions
 - a resource person with improvement skills
- The balance of full-time versus part-time staff (It is easier to pull meetings together with full-time staff rather than part-timers).
- Is it reasonable to start with teams who have no experience with QI methods or improvement projects or initiatives? The collaborative may be a more advanced QI intervention with timelines that require too steep a learning curve for building QI methods capabilities. Is it realistic to think that a team from an organization that may not have QI structures or supports in place onsite would be able to learn all it needs to learn while doing all the improvement work?

4) The critical resource - time

Discussion points:

- Managers play a central role in giving staff time to work on the project. It bears repeating that ensuring that the unit manager is supportive of the project is a critical success factor.
- There may be value to trying to estimate more explicitly the resources required for all stages of the project; not only attending learning sessions, but also all the rest of the tasks. This should be part of the planning discussion in each organization at the outset of the project.

5) “Visible bodies” - the day-to-day change champions

Discussion points:

- Any improvement initiative will require hands-on coaching and education, day-to-day contact and follow-up with the staff members who are making changes to their

practices. Do team leaders and team members have the skills, time, and resources to do this work? Are there others on the unit who can also fill this role?

- We know that educating staff members may be inadequate to make or sustain changes, yet we often rely on education as the main means of change. Teams may need process thinking skills to help them change structures and processes, the context and environment, in addition to their interventions based on educating staff members.

6) The rapid cycle methodology

Participants thought that PDSA was wonderful and many teams took to heart the advice that they should “start small.” Unfortunately, by making changes with one patient at a time, some became stuck on one patient.

Discussion point:

- Given that the specific patient mode of thinking is so pervasive and powerful, those running collaboratives face a challenge: how to leverage the communicative power of individual case stories but provide concrete examples of how to move thinking towards multiple dots/data points for PDSA cycles and ramps of multiple PDSAs. Including even brief discussion of process mapping and analysis may help.

7) The value of the learning and exchange opportunities

Participants valued the learning sessions, the teleconferences, and list serve.

Discussion point:

- Participants were worried about losing the access to the resources and the experts when the project formally ended. Several wanted some form of structured support continue, for example the list serve or even follow-up teleconferences to discuss results and issues related to sustaining changes. Some form of continued support for teams, if feasible, should be discussed when planning the project and with participants.

8) The coaching role and coaching challenges

Participants spoke very highly of and greatly appreciated the work done by the coaches.

Discussion point:

- It is interesting to consider what the role of the coaches *should* be. The support they provided could be very labour-intensive; would they have been able to do the same if there were more than a dozen teams? Given how the teams were formed and the organizational contexts in which they worked, many required fairly intensive support. What level of support is reasonable for the teams to expect? What level is feasible to provide? The title "coach" implies a fair amount of contact and direct facilitation with the teams or at least the team leaders. In fact, the coaches sometimes acted as personal coaches for the team leaders. At what point is it a full-time job to provide that level of contact and support - when coaching four teams? Five? A specific job description would perhaps help role clarity and could be shared with teams.

9) Spreading and sustaining changes

Participants told of mixed success in spreading and sustaining the changes. In some instances both the clinical process changes and the improvement methods took hold, but in many organizations it was the PDSA methods that have spread far more than have the clinical changes.

Discussion point:

- The reliance on few day-to-day change champions - combined with the difficulty of moving beyond the one-patient focus - made the change efforts fragile. How can collaborative experts help teams start planning for spreading and sustaining changes early in the project?

10) But they are willing to do it all again!

For all the challenges and obstacles the teams experienced, participants clearly thought the benefits far outweighed the personal and organizational costs of the time and effort they invested. All five teams would participate again if given the opportunity.

**LEARNINGS
FROM THE
IC 5 COLLABORATIVE
EXPERIENCE**

Introduction

The IC5 Collaborative was a quality improvement project conducted by the Hospital Report Research Collaborative (HRRC) during 2004-2006. The project’s dual purposes were to improve continence care in complex continuing care organizations in Ontario by using collaborative improvement methods and to study the effectiveness of such methods. The project was carried out by the University of Toronto IC5 research team, comprised of principal investigators, clinical and improvement experts, coaches, and a project manager, who supported teams from twelve participating organizations.

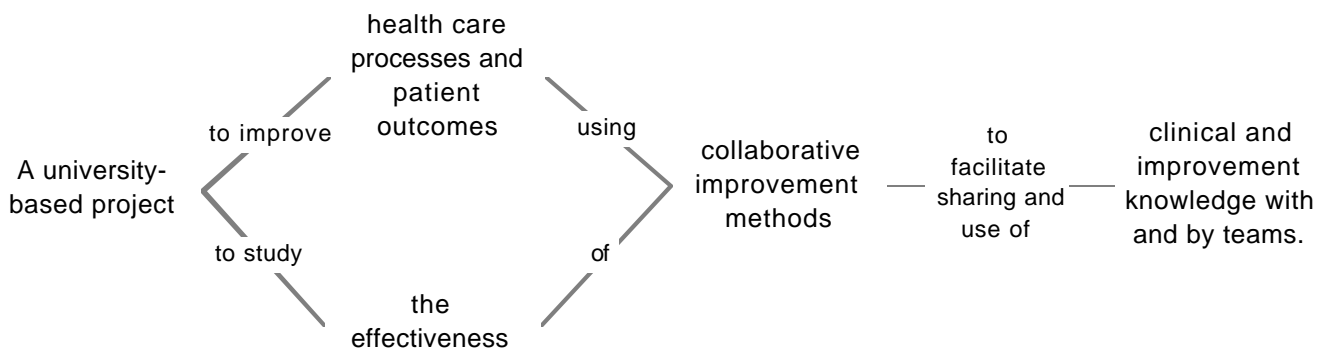


Figure 1. IC5 project’s dual purposes.

In addition to the full research evaluation of IC5 by the principal investigators, the IC5 team was interested in the participants’ views of the collaborative. The intent was to learn about the project processes as experienced by team leaders, team members, and senior project sponsors within the organizations, with the goal of informing future collaborative improvement efforts. Members of five teams from different organizations and the three IC5 coaches were invited to participate in in-depth interviews after the conclusion of the formal project. (See appendices for interview questions and methods.) This report summarizes insights and lessons learned synthesized from the interviews with thirteen individuals from the five organizations as well as the three coaches.

The schematic of the IC5 project (Figure 2) is a high-level representation of the main activities. Moving through the diagram from the top, the project activities can be described as a series of processes:

- The IC5 team enrolls organizations to participate in the collaborative.
- The organizations designate senior project sponsors, form their teams, and provide resources for the teams.
- The IC5 team provides clinical and improvement information to the teams through learning and exchange opportunities, including the three learning sessions in Toronto, teleconferences, the project website and list-serve.
- The IC5 coaches maintain contact with their designated teams and provide support to the team leaders and members.
- The teams participate in the learning and exchange opportunities.
- The teams test a series of changes, which then are spread within the participating units and through the organizations and are sustained over time.
- The teams report activities and measures.
- The teams celebrate their accomplishments. The IC5 team and the organizations recognize and reward the teams' participation and accomplishments.
- The IC5 team gathers data to study the processes and outcomes.

Even though this appears to be a straightforward list, these activities represent complex interactions. Interview participants described quite varied experiences with the processes. The following sections elaborate on the participants' views of what worked well, challenges they experienced, and suggestions about what they would do differently. Each section of the report highlights key themes related to these main activities, illustrated by quotes from the interview participants.

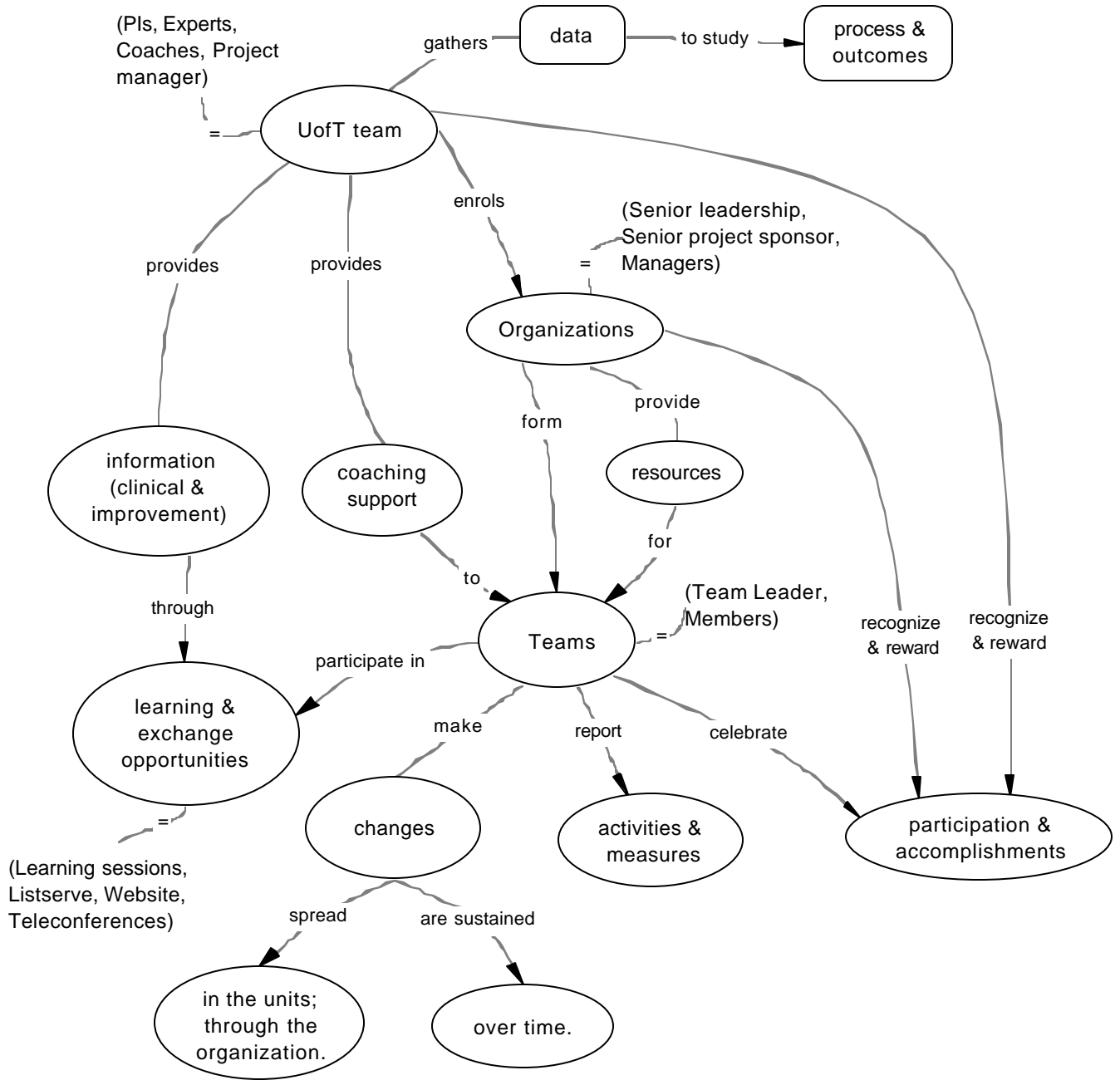


Figure 2. Schematic of the IC5 Collaborative Project

Overall benefits of the Collaborative

“...I find it’s amazing when you see the synergy of so many organizations... You feel great when you get together and share your experience, share the challenges you have. They make you feel like you’re not the only one...” IC 5 Team Member

Before delving into the more specific themes, it is important to emphasize that all participants interviewed were enthusiastic and very positive about the collaborative. **Key elements that they valued very highly include:**

- Access to the expertise and resources (clinical and improvement),
- Contact with the coaches,
- Learning the rapid cycle methodology,
- Opportunities to share experiences with peers and to build networks,
- Structure provided by the collaborative (to help keep them going), and
- Recognition and celebration.

The following quotes are from a team leader, team member, and senior project sponsor from three different organizations, yet the message they convey is consistent with what I heard throughout the interviews.

It was a good experience, there’s no doubt in my mind that we wouldn’t have achieved what we achieved without the collaborative. I can’t imagine, I would have had to create the learning packages, I would have had to get all that content, I just can’t imagine it without IC5, without the collaborative, so I think the uniqueness of that made my ability to transfer that knowledge much, much easier. I used all of the content right from IC5, I used all that material, I used it live for my workshops, I might have taken some out and included some but I did very, very little changes to it so that was wonderful, wonderful. (Team Leader)

Oh, it was fantastic. I found it’s kind of amazing and it was my first time, I understand this is also the first Ontario multi-hospital collaborative initiative. I find it’s amazing when you see the synergy of so many organizations. It was a very good experience for me. The strengths I have seen are the synergy of knowledge and even motivation. You feel great when you get together and share your experience, share the challenges you have. They make you feel like you’re not the only one. I like the generosity to share information when you see something at a learning session, you can ask, you know, can I call you, can I get this. (Team Member)

Oh, it was phenomenal. I guess I won't speak on behalf of the organization just now but for myself this was by far the most successful collaborative I've ever been involved with and I've been involved in many - communities of practice, stakeholder groups, interest groups, etc. etc., many other types of groups where people are supposed to come together to talk about common issues and take some sort of action and what you realize is that you may talk about the issues but very little actually gets done. This is the first time I've been involved in a collaborative where in such a short time, a year is small in the scale of healthcare, where we've actually been able to show some tangible results. (Senior project sponsor)

While the participants all said that they gained from their overall IC5 experience, interesting differences were apparent in their responses to questions about specific aspects of the project. The contrasting responses illustrate the kinds of factors that facilitate - or the converse, issues that impede - collaborative improvement work.

The key themes include:

- **Clarity of expectations - understanding requirements**
 - Communication between senior leadership and project teams in organizations.
- **Team composition - getting the right mix of people**
 - Clarity of expectations (again)
 - Cost considerations
 - Characteristics of workforce and members
 - Improvement skills and change champions
 - Intact teams
 - Competing priorities
- **The critical resource - time**
 - Is the manager on board?
 - Are senior leaders aware of the work involved?
- **"Visible bodies" - the day-to-day change champions**
 - What do these day-to-day champions do?
- **The rapid cycle methodology and PDSA**
 - The importance to the teams of learning PDSA and "start small".

- The trap of starting small: difficulty moving beyond one patient or resident.
- **The value of the learning and exchange opportunities**
- **The coaching role and challenges**
- **Spreading and sustaining changes.**

Clarity of expectations

"...I know the staff had mentioned frequently to me the fact that they knew exactly what was coming next...They knew what they were getting themselves into..."

Senior Project Sponsor

Organizations varied widely in how they made decisions about joining the collaborative, how they communicated about IC5, and how they started their teams. Several contrasting situations unfolded depending on the extent to which expectations about the project and roles were clearly understood by senior leaders and how they engaged staff in planning.

In a positive example, one organization's senior project sponsor indicated that "they knew what they were getting themselves into" based on communications from the IC5 project team at the outset.

*I guess the word that I'd use to describe is that we felt very supported. From the very beginning, there was excitement with being involved because the communication around the project was very clear, not only to the team that was directly involved but to the senior management committee. It wasn't volumes and volumes that we knew we would set aside and not get to for a while. It was very succinct but we knew what our role was and we knew where the project was going and what's important in the end. I think the timelines, I know the staff had mentioned frequently to me the fact that they knew exactly what was coming next, from the very beginning they knew that in six weeks you have to be in Toronto for a training session and 3 months after that you'll be presenting so there weren't surprises along the way. They knew what they were getting themselves into.
(Senior project sponsor)*

In this organization, the decision to participate in the collaborative involved the team leader and the manager who was responsible for staffing and resources on the unit where the project would take place.

By contrast, participants from several teams said they had no idea what to expect when they were asked to form or join a team and attend the first learning session in Toronto. Several suggested that it would have been a good idea for the IC5 Project Team to have organized

some discussions about what to expect, the suggested team composition, and the resources that would be required. Given that these details were in fact included in the documents sent to the organizations' leaders as well as in early conference calls, this information evidently was not passed along within all organizations. For example, in one case an administrator signed up the organization and the project "filtered down" to the senior project sponsor, who commented on the need for more in-house preparation and planning.

Well, I think anybody that was involved from I would say the senior perspective meaning myself, the managers, the nurse clinicians, the education people...we found that it was wonderful - because we could see where it was going. The difficulty was trying to get the frontline staff motivated to stay involved and from the get go, I think that it was, I don't think that I paid enough attention to really understanding the project to keep it focused because I think in the beginning there was a couple of people that were on the team that were overly ambitious and when we went to the very first workshop, we had these grandiose ideas about that we're going to go 100% with the patients and I kept saying well this is too ambitious but that key message did not come through I don't think from [the IC5 Project team] until later in the process so at the beginning I, I take some responsibility in that I think we were too ambitious so I think we lost time at the very, in not doing enough planning and discussion at the beginning of the project to say let's focus on one unit which eventually we did get to but in the beginning I think we lost time without doing enough in-house preparation and planning. (Senior project sponsor)

Discussion point: What is needed to ensure that communications are received and understood by the organizations and that appropriate planning takes place prior to committing to a collaborative? Organizations would benefit from a frank self-appraisal of both their capacity to take on yet another project and their improvement capabilities, to make sure they can provide the support that teams require.

Team composition - getting the right mix of people

The way teams were organized was of critical importance, as noted by this team member:

I think it was interesting how the team got formulated here and who got selected for the team. It was interesting how they would select team members for other projects. I would say definitely that frontline people need to be on the team and you need to pick self-starters, motivators and give them some ideas to help keep things going, but the selection of the team is extremely important in terms of getting projects going and the success of the project and that would be the first thing the hospital needs to take a look at is who they select and how they select people. (Team member)

Multiple factors come into play in decisions about team composition, including (again) how clearly the guidelines provided by the IC5 Project Team were understood, cost considerations, desired member characteristics, need for improvement skills and champions, and whether to choose an intact team (people who normally work together).

"...I think because it was the first initiative like this, I don't think people knew who the appropriate people were that should have been on team..."

IC 5 Team Member

Clarity of expectations (again)?

The differences in how the organizations understood and signed up for the project carried over to how they structured their teams. Once again, it seemed that there were gaps in communication about the guidelines in some organizations.

I don't know whether you know but initially when we planned the work, when people started recruiting members, I don't know whether they have some guidelines, who should they recruit. If there is some kind of suggestion or guideline, it may help the team to kind of formalize the team to recruit team members. I think that different teams might have had different team members. For some people on the team, it almost came to the end when we recognized oh it might be good to have a front line worker and to me this is key. When you want to change something, especially from clinical perspective, the front line provider

is the key and I think it might be good for each team to have one of those. They are the ones that might be able to influence a change too. So that kind of approach from the very beginning, to kind of give some advice on how do you form your team, who might be a more ideal member on this team. (Team member)

Although suggested guidelines were sent to the organizations, team composition was not always appropriate, as described by one coach.

Well, initially when we sent out the letter...so once hospitals decided they were going to sign up and we sent out a letter with definite parameters on who we think should be on the team so we talked about a frontline member, a decision support person, a senior leader who would be the champion, we were very specific on who we thought should be on the team and we also realized, and we said this in the letter, we realize that hospitals differ in regards to their staff composition. This is just a suggestion as to what the mix should be. So we gave them a range, you could have four to six people as long as you have this mix of people so even though we gave these parameters and these directions, at the first learning session hospital teams, not all of them, I would say maybe out of the 15 that 11 or 12 came with the appropriate mix. (Coach)

Cost considerations

One organization felt they could not afford to send more than four individuals to the learning sessions, both due to travel expenses and the cost of replacement time for the nurses.

[S]o we just talked about who we would want involved given the guidelines that were set out in the project literature and knowing that we probably couldn't pull together a team of 8 or 10 people, I'm sorry I don't remember what the recommendation was but we did streamline it through our organization. [Team leader] was quite confident that the number of people that we chose and specific people that we chose would be enough. They could manage the project. (Senior leader)

The issue of staff time will be addressed separately in the section about resources.

Characteristics of the workforce and individual members

The team leaders had to juggle a number of factors when trying to plan for and recruit the optimal mix of team members. Several mentioned challenges due to the large proportion of part-time versus full-time staff and the higher ratio of licensed practical nurses to registered nurses.

So I had nurses, I had two on board so I wanted more, I wanted an RPN and I couldn't get more. I wanted another full time person but couldn't get them. But that also speaks too I think to our ratio of full time and part time nurses. It's rich in part time but not in full time. (Team leader)

In some instances, team members were carefully chosen from the start because they were enthusiastic frontline staff with clinical credibility, recognized as potential change champions: "Individually I think [the team leader] specifically picked people that she knew would be positive and enthusiastic and would be well received by their peers" (Senior Leader).

It's a great team to have. I was really pleased with the team. They all had different qualities that they brought to the process. The [allied health member] on the team [name], she's young, she's bright, she was good at the analysis, the thinking, how can we do this differently? She has a lot of great ideas for that. So people brought different strengths for that whole process. (Team leader)

Although a few participants felt they had the right mix of people from the start, several noted that with hindsight they should have made changes (or made them earlier), such as adding individuals (more front line staff, individuals with improvement knowledge, clinical staff) or bringing in individuals as needed rather than as full members.

I think because it was the first initiative like this, I don't think people knew who the appropriate people were that should have been on team, they were kind of trying to pick and choose, so in hindsight, this was one of the learning things that we found is good, I could have been a consultant and it might have been more beneficial to have another clinical person on the unit so that was one of the learning experiences that we learned here is again we weren't clear as to who the appropriate people were to be on the team. (Team member)

Improvement skills and change champions

The need for individuals who could act as change champions in the units and the need for "process leaders" who had improvement skills came up several times.

Oh I know [team member] said the team should have been bigger. She thought we could have benefited from more, I think she would have liked a couple of other champion nurses. (Team leader)

I think if I was going - going back to one of your earlier questions 'if there was anything I would do different?' - I would, if I had two [staff members] I would look at the one with the strongest process methodology and the one who I thought could create an impact with the rest of the organization so that I could use them in the rest of the organization. [Several team members] are great within their team but have not demonstrated that leadership practice within the organization so it's tough then to, even if you had the time to do that, you have to provide them a lot of support or give them additional training. They have to want to do it. So you know if I was to do it over again, I might have added somebody who I would have though could have been a process leader just to learn the process skills and then use them to help as a resource to other team members. (Senior leader)

The presence (or absence) of such individuals on-site influenced whether changes spread or could be sustained. This also had implications for the role of the team leaders and the coaches. At least four of the teams, if not all five, did not have basic QI knowledge or skills when they joined IC5. Team members faced multiple steep learning curves relating to the clinical content, the QI methodology, the collaborative processes and culture, and their own organizational context (culture, politics, resource issues, resistance to the changes from unit staff, lack of support from managers). The IC5 Project Team had to help relative novices get up to speed enough so that they could go back to their organizations and actually try some changes. The coaches worked hard to support multiple teams who experienced the problems related to their organizational contexts.

Discussion point: Is it reasonable to start with teams who have no experience with QI methods or improvement projects or initiatives? The collaborative may be a more advanced QI intervention with timelines that require too steep a learning curve for building QI methods capabilities. Is it realistic to think that a team from an organization that may not have QI structures or supports in place onsite would be able to learn all it needs to learn while doing all the improvement work?

These points will be discussed further in the sections on spreading and sustaining changes, “visible bodies”, and coaching challenges.

Intact teams?

Several teams were made up of individuals from various units and departments in the organization as compared to intact teams of individuals who regularly worked together in one unit.

I think I was involved partly because the team that we pulled together was not what I would call a naturally occurring team. It was one person from CQI, one person who's Admissions, more responsible for Admissions, a nurse on one of the units, a physio on another unit, a staff nurse who started with the team because she was doing a three month fellowship but then went back to being a nurse at the bedside so these team members didn't work together every day. They were really coming together for the purpose of this project. (Senior leader)

An advantage of this structure is the opportunity to involve multiple areas in hopes of spreading the changes more widely in the organization.

We work on different units so it kind of gives us the opportunity being a champion for individual units. We are able to observe different things on each unit and then we were able to bring it back at the meeting. (Team member)

However, this structure can leave just one team member to act as the project champion and change agent in their unit. The difficulties this creates are discussed further in the section “visible bodies”.

Competing priorities?

For some organizations, the process of getting a team up and running was a struggle.

So then we had to strike a whole new team because there was just no uptake. Now the other piece to this on one of the initial units, so we were in the middle of clinical restructuring so we didn't have any manager there to support and then we lost the clinician so because of the manager's buy-in on one ward, then we restructured and focused in one unit so then when I lost the clinician, I asked one of my staff, one of the education specialists to assume responsibility to work

with the manager and there was a clinical nurse specialist that worked in this particular ward so we just regrouped and struck another team and then went forward from there. (Senior leader)

Competing corporate and/or unit priorities, organizational restructuring, downsizing and budget issues, and lack of support from unit managers; a mix of these factors undermined some organizations' efforts to structure teams and, at best, created difficulties for others.

Discussion point: There are a range of factors that must be considered when initially organizing the improvement teams:

- Whether to have an intact team or a team with members pulled from various parts of the organization
- The need to include
 - front line staff who know the care processes
 - both allied health and nursing staff
 - individuals who are enthusiastic, have clinical credibility, and can act as champions
 - a resource person with improvement skills
- It is easier to pull meetings together with full-time staff rather than part-timers.

The critical resource - Time

"...it took a lot of commitment from all us to try and make it work..."

IC 5 Team Member

Trying to fit improvement work into their busy clinical work schedules in the midst of other competing priorities was a significant challenge faced by all teams, as described by one coach.

I think on the surface their CEO and senior management were supportive but I say on the surface. I don't know even know whether they, I think they also had competing priorities within the organization and I believe accreditation was one of them. So that was another example where it seemed that if senior management didn't make it one of the priorities, I think that that CEO really wanted that hospital to be part of it and wanted it to happen but I don't know that the team and the staff were actually given the time and the resources to really make it successful.

[T]he chief complaint was about time because they weren't being given dedicated time to the project. So that was usually the chief complaint that if they had been given the time or special specific no other things on their agenda for that particular day or hour or whatever, they felt they would have done a lot more but they were expected to do their regular job plus IC5. (Coach)

One team leader described the time commitment and the nature of the ongoing follow-up work required to sustain the effort.

Well, it took a lot of commitment from all us to try and make it work. I think the time it took from me was doing a lot of the background work in making sure the pieces were together and doing the things like the PDSA cycle and making sure we were doing the documentation and kind of doing that background preparation so that the team could then make it happen on the unit. You know we have a binder set up on how we triage things and trying to get the proper forms done and things like that. That's more where my strengths were. It's time-consuming, you have to make the time to do that. The other thing we still need to work on and still are is committing to keeping it up to date and keep people reminded that the project is still worthwhile so it still takes time. From a financial point of view we didn't have any funds to educate staff to release them from their workplace so we had to do it all within our budget. (Team leader)

The coaches noted that the resource intensity of the project appeared to vary by team, with some organizations having a better sense of what would be required based on previous project

experience. Even those teams who appeared to others to have an abundance of resources (such as continence advisors) commented about the intensity of effort required.

Is the unit manager on board? Are senior leaders aware of the work involved?

The unit manager is pivotal in making staff time available. It made an enormous difference if the unit manager was “on board” and supportive and had a good working relationship with the team leader. The manager’s role in giving staff time to work on the project came up so often that it is obvious that ensuring that the unit manager is supportive of the project must be a critical success factor. However, the managers who are accountable for the budgets were not always on board and often the senior project sponsors did not appear to be aware of the extent of this, as shown by the following comments from members of one organization.

*My philosophy is if you keep them engaged and involved, you pay for it up front, you reap the benefits long term because they’re not going to be off sick or that so we just pay what it takes. We pay for them to go to nursing practice council, I support them, the different activities, it’s always just part of, they get straight time.
(Senior project sponsor)*

Well, I think it comes down to time and money, time and budgets, staffing. The authority to push it through because [Team Leader] has got a certain amount of authority but she even is, her hands are tied when it comes to the staffing issues I’m sure. (Team member)

*My resistance came kind of early from the manager who was concerned with budgets, staff replacement because there was no money to replace staff when staff went away and while we have education days in our budget, there are only so many and there were many other initiatives happening at a corporate level where the dollars weren’t there so that was a huge, huge struggle. I wanted more staff [involved in the project] and I pushed very hard to get that and I didn’t get it.
(Team leader)*

Some senior leaders appreciated the effort that the project would require but did not have the resources to pay for release time for all team members. They acknowledged that their teams were spending unpaid time on IC5 tasks and tried to find ways to recognize and reward them.

As far as...there were only two nurses that we had to replace while they were off. Unfortunately the other individuals on the team their work just piled up and waited for them. We knew that there was going to be a commitment as far as the number

of days that they'd be off site and the staff committed to that themselves so that was very upfront that they would be going. I know the team put in a lot of extra hours meaning after duty or over their lunch hours as well trying to make it effective but they loved it. We didn't even have to ask them to do it... The odd time there was something around the work load and we'd try and adjust their schedules to accommodate that. We tried to compensate for some of their extra hours that they put in etc. by seeing their trips to Toronto, I know it sounds silly coming from here, but their trips to Toronto as a group, we tried to make that a celebration. Go out for dinner, have a nice evening and enjoy yourselves, so they were very appreciative that they had the opportunity to be involved. (Senior leader)

Unfortunately, there were other instances where the senior leaders did not seem to be aware of the gap between the paid work time available and the time actually required, underestimating the resource intensity of the project for the staff.

*I mean other than time, other than the clinician's time and having to travel the three times when there were face-to-face meetings, that was pretty much it. I mean we didn't incur any additional expenses. It didn't mean that we went out and purchased a whole bunch of new supplies or had to photocopy a whole bunch of new things, it was really the time of the team members. **We pay them whether they're doing this or something else so it wasn't additional expense for us.** It was the travel expenses for people going to two days of meetings three times, mind you that was just planes, trains and hotels. Some meals were provided by the IC5 team so it was some expense, I mean, people generally budget for that. If you're so strapped that you wouldn't be able to afford sending somebody to an offsite meeting, then that's an issue. For us it was okay. (Senior leader) (my emphasis).*

Team members often painted a very different picture of the actual work involved, emphasizing how much rested on the shoulders of a few individuals who worked on their own time on the project so that they could keep on top of their regular responsibilities.

It's huge... [Team member 1] and [Team member 2] are trying to do this on top of their day to day work. It doesn't work. You can't be expected to have your normal full load like every other person and try to implement this. It just doesn't work. There's no, so the resource intensity is huge and if you don't have the right, that's why it's fading away because you cannot sustain this if you don't have the resources. I mean it's people and the money resources so, like this is a big piece. I mean even for the quick huddles to be able to pull off the floor, [a team member]

couldn't make half the meetings because there's crisis on the floor so she couldn't come. I mean you have the best intentions that you're going to be at the meeting or she was on nights so we tried to have the meetings first thing in the morning. Unless you have your resources that are given protected time or even a short amount of time but you can't.

[Team leader] had a bit of protected time but the rest of us, no. This was part of our everyday load. I mean like [Team member 1] was coming in to meet the nurses at 7:15, her shift, I mean she's supposed to work 8 to 4, she works very long hours normally but it's not, you're not paid for it, it's above and beyond. I think it's a lot to ask of people on an ongoing basis. I mean we're all willing to come in early or stay late periodically but this kind of thing is not a periodic thing. You need to be there a lot. Even with the survey questionnaires, all of that stuff, you need to be there, you need to sell it to the people, "Here, could you please do this?" I mean [Team member 1] gave pens and like she was very, but there's no money for that, she took that money out of her own pocket, her time was out of her own time. There was no extra money in the budget for any of this stuff that I'm aware of anyway. I mean yes, we got sent to Toronto and I think they budgeted for that but there's really no extra money to do this. This cost, I'm not saying it's not worth doing or anything like that but it's something that has to be considered. (Team member)

There is an interesting tension relating to the time required by the teams to work on the changes and how it was suggested they do this. They were encouraged to think of ways to build the improvement work into the structures and processes of their daily work, so that they would have huddles on the unit or have discussions in rounds (not meetings behind closed doors), for example. But by analogy, if a solution is already saturated, adding more material will cause it to precipitate, and in this case, the fall out was extra work for many participants on their own time. There are different types of work and time required for the projects, including the coordination by a team leader (e.g., the project tracking, paperwork, and communication); the facilitation and follow-up on the unit with the frontline staff; testing changes to processes by the team members and the staff; the team discussions about what is working or not and what to do (huddles); the data collection and documentation (both of the change work and evaluation components such as surveys); the preparation of presentations for the learning sessions; and the internal communication about the project. There may be a risk if senior project sponsors underestimate all of this, as well as the work it takes to learn how to build the improvement and change tasks into the daily work.

Discussion point: There may be value to trying to list more explicitly not only the resources required for attending learning sessions, but also all the rest of the tasks, and estimating the time implied by the types of work and effort required. This should be part of the planning discussion in each organization at the outset of the project.

“Visible bodies” - who are the day-to-day champions?

“... If you don't have somebody who is in a supervisory role to constantly be following up...following up the initiative ...the motivation is not there.”

IC 5 Team Leader

Another central theme is the essential role of the individuals who work day-to-day to implement the changes on the unit with the front line staff. In some instances this was carried out by the team leader, but in other organizations team members

undertook this work. One team member coined the very evocative phrase “visible body” to describe that role.

So I think with any change, get the team to make sure you have a visible body to support the staff for that change. A visible body is a person that is accessible, approachable on the unit when the staff needs them. It's not somebody who is kind of removed from the clinical side. Yeah, kind of close to the clinical side in case they have questions, they make just a call and they get the support. (Team member)

Many participants talked about the specific hands-on work of the visible bodies and described just how much it really takes to make changes in the units. It requires a huge amount of consistent follow-up contact with the staff, direct and concrete coaching "to get things moving and changed".

We tried to then expand beyond the IC5 team members and the larger clinical group was initially a challenge for us. I think it was trying to engage the other clinicians in the improvements. For example the advanced practice nurse had a strategy where she would basically assign a nurse and a patient with a catheter. She would always come back to that nurse and say so what have you done with that patient and what have you tried and so forth, in a sense not just saying this is a great new improvement and you should be now doing this, we had to be more directed and more concrete. Okay, next week why don't you try this with this patient? So it was quite directive and I guess we didn't realize starting off what did it take to get things moving and things changed in that way. (Team member)

Similarly, a team leader commented that efforts to make changes failed when their “visible body” was absent on a weekend. She observed that even motivated, very good staff need encouragement and reminders through ongoing contact.

I mean the first time we did it, we found that staff, it was on a weekend and we thought oh well, it would be quieter, we'll do it Friday, Saturday, Sunday so the staff on Friday, we reminded them to keep a voiding record, all those things. It didn't work, I think because we weren't there to sort of bug them so then we had to go back and say okay that's not working, we're not getting the proper information so we tried to pick a day when the staff nurse was on during the day so we did some of the modifications and I think probably the daily contact with staff saying we can make a difference. ...I think it's just the consistent follow up that makes a difference in these projects. The staff here generally do want to provide really good care. They're very, very good staff. The follow-up staff would say let's try this today, let's get this patient going or yesterday this patient was continent and that was really great. Just that little, letting staff know that. Those of us on the team, I think we all make a big effort to talk about it. (Team leader)

By contrast, a senior project sponsor portrayed this as a need for a supervisory role accountable for follow-up with staff, given that staff are under the pressure of their job responsibilities and not motivated to undertake changes.

I would say for me it was a wonderful opportunity because it was a provincial research initiative, it was a huge initiative but I mean it took up a lot of my time to monitor just trying to keep things on track but in terms of the resource, having one person dedicated or a big portion of that person's time, I would say at least a .5 of a clinician to do it justice and to do a good job of it. If you don't have somebody who is in a supervisory role to constantly be following up, be following up, following up the initiative and the motivation is not there. People are consumed with trying to get through a shift, to do the bare essentials so when you're trying to make practice changes, that's what I find is resource intensive is having the time to engage people and follow up to see whether it's been done, if it hasn't been done, how come it hasn't been done, did someone do it wrong, how can we correct it. So it is a huge initiative. It's got to be somebody's job. Somebody has to be accountable for this. (Senior leader)

What do these day-to-day change champions do?

It can be a significant challenge for the day-to-day change champion to engage staff in making the changes. In some instances, this person can end up doing the work themselves, with the danger that if he or she stops and others do not carry on, the whole initiative loses momentum, as described by one team leader.

The initiative for them to do the assessments is still not there so I've got to follow up on that. I think if I didn't follow up, I'm not sure what would happen. I think that's up to me, the accountability and responsibility..., that's what I believe and I think if you don't have that, things go by the wayside...When I started off I was doing assessments, I am now not doing any assessments. Staff are doing them but we're still only reaching 50% of the population, of the patients on that unit that need it. It hasn't spread yet. I probably can't. I realize that I probably can't. I would need others.

The work of day-to-day change champions is a combination of implementing changes to processes, just-in-time education for staff on the unit, and building momentum to keep the staff involved and motivated. I was astonished to hear about the extensive efforts of another team member to support the changes on her unit. The following quotation is somewhat long but is well worth reading for the detailed description of this visible body's efforts.

The camaraderie of the frontline people that were initiating the projects on the floor was very high. Enthusiasm was good. We also had the opportunity, myself on the floor, I was the generator of the package on this floor so I could introduce little initiatives, get little fun games going, give little sticker awards, little graphs on the wall, do something that would inject some fun in the process. If it's not fun, it's not exciting to do people aren't going to do it. We've got lots of drudgery to do every day so you have to inject something new, something different to get the momentum up to keep things going and rolling and that's what was fun about it.

To build momentum, we decided we were going to select ten people on the floor so we started with one person. We had little thermometer graphs so that we'd know who had done the assessment, one assessment up to ten like you do with the fund raisers when you're reaching your goal, a little thermometer that goes up.

We had a little reward beside the names so that people who had actually done the assessment, the nurses that had participated and the nurses that had helped to write out the plan of action for care that they would get recognition because they were the ones that had done it so they get their names put on it so people get to see who was participating in it. In the mornings when I do my little education sessions, once a week when I do my session, I go into the opening rounds in the morning when they divide up the teams for the various modules, I would have five or ten minutes at the most so I would have a quick information bullet, ask a couple of questions about the one before, give out little rewards like little chocolate bars or a little something like that as a little reward "oh, you got the right answer. Here's the chocolate bar, here's whatever" so just a little fun thing so people would

say what's going to happen today in that ten minute education bullet because it's amazing what you can teach and learn in ten minutes and then say alright, let's carry that on today and go down the hallway, then as I go down the hallway in the next few minutes, ask again what was the diaper's acronym for? What was the da da da for?

So you're just trying to carry that momentum along or you give people a little sticker that they had attended the conference or little reward stickers for patients that were on the thing in terms of going to the toilet, they had a calendar and little success stickers and they said "I did a great job today or marvellous or fantastic" or whatever, just a little something so that they got into the excitement and enthusiasm and they could show whoever came in and said "Oh, I got a sticker from [Team Member] because I did such and such today," so it just builds up the enthusiasm. Just little initiatives that just tried to add a little excitement into the learning thing that it wasn't just a dull learning package and then you're going to go off and say okay, everybody try and do whatever it is. They want to try and do more with less and whatever so we just tried to add a little excitement into the whole process.

It raised a profile. We had the thermometers everywhere at the nursing units so we knew where we were on the project, we knew what our goal was we knew the timeframe that we had to achieve it in so we knew where we were on the process. It also, by having the IC5 logo around and displayed around, the families were aware of what we were working on so they could buy into the process as well or ask about the project was and am I included in it or am I not or whatever so it helps with the family buy into it as well so they have an idea of what some of our CQI initiatives are and what we're working on. If they didn't get feedback through one of the other mechanisms, this is one other way that they have to see that we're working on something. So it raised the profile of the project as well.

Just-in-time education and quizzes with prizes of pens and chocolate, charts with names of staff members who participate, stickers, thermometer posters displaying the number of patients successfully included in the changes, the IC5 logo displayed to raise awareness, quick pop quizzes with follow-up questions for staff members during the shift; all admirable efforts to educate staff and build enthusiasm. However, the initiative's continued success on the unit may depend on the ongoing work of this one team member, *unless* a) a critical mass of staff members have absorbed the changes into how they do their work, and b) the processes and procedures themselves are changed, so that when staff turn over, new employees learn the new process.

As one team member commented, “It has to be seamless. It can’t be ‘Oh, they are giving us more work to do and no time to do it in’.” The need to change the processes, not just educate the people, was also raised by another team member.

So that rather than trying to get everyone involved right away, we chose to sort of strategically who were involved and we did test out going to just any nurse, whether or not they were an early adopter or not and saying you know we’re trying to make these changes, do you think with this particular patient the next week you could try and do this, that was another strategy. But we felt we also wanted to look at what our processes are and how can we make the process easier? How can we make it so that we’re replacing something that already exists and try it that way rather than trying to educate every nurse the same way? (Team member)

This highlights the need for process thinking capability, which may have been lacking in the teams. Process thinking includes the ability to move between levels of abstraction, from the conceptual view of processes and changes that can be made to the more concrete level of testing changes on a patient-specific basis, and back again. If teams do not have this capability, the change efforts may depend on the continuous presence of the visible bodies working one-to-one. Another risk of the labour-intensive one-to-one work is getting bogged down and making changes for only a few patients, as will be discussed in the next section.

Discussion points:

- Any improvement initiative will require hands-on coaching and education, day-to-day contact and follow-up with the staff members who are making changes to their practices. Do team leaders and team members have the skills, time, and resources to do this work? Are there others on the unit who can also fill this role?
- Although we know that educating staff members may be inadequate to make or sustain changes, we often rely on education as the main means of change. Teams may need process thinking skills to help them change structures and processes, the context and environment, in addition to their interventions based on educating staff members.

Rapid cycle methodology and PDSA: “Build a seed, grow to the flower, grow to the field, grow to the farm”

“ I like the PDSA model. I have in mind to train the managers on it because I like the concept that you just get in there and give it a try...”

IC 5 Team Leader

The importance to the teams of learning PDSA and “start small”

When I asked participants about the most significant thing they learned from their IC5 experience, a few commented on some aspect of continence care, but the majority promptly responded with “PDSA” and/or “start small”. As the team member quoted below noted, “we were going to continence, but we actually got the change management.”

PDSA. I just love it. I had never heard of it. I mean I've taken a master's level course on change, never heard of PDSA so for me that was like the 'ah ha' moment. I don't know how else to say it. It's like what a great way to keeping a change that we see outcomes right away. Because I always found it so frustrating, I mean I've worked over the years, I've worked on so many projects that we've worked, worked on, worked on and they never went anywhere and then how you get people to buy in...people don't want to take part in projects because it's like oh no, here we go again, whereas this is like okay you can actually see right away. You can do something right away. I mean nurses or healthcare professionals are doers. We want to fix it; we want to do it we want to do it now so this I think is a good way of getting people to buy in, getting people to get excited about stuff. I mean if you devise a form and you try it and you think okay, this worked, this didn't work and you can do it, it's like instant gratification almost, like sugar you know? But nurses need, I think not only nurses, healthcare professionals need to see results. They don't want to do stuff just to do it and there have been too many projects and it's like here we go again, it's the flavour of the month. So for me that was the biggest.

[T]hey embraced this PDSA because I think they saw the benefit of it, like I said instead of studying something for a year and then trying to implement something and then finding out oh yeah, but this form doesn't work. Well, they're already okay well, we're going to try it on one or two patients and then we're going to go back to the drawing board and see. So that I think that has taken root because again it's an easier thing to sustain than a knowledge and skills, you know? Which is kind of a funny part when you think about it, I mean, we were going to

contenance but we actually got the change management. (Team member)

The notion of starting small, with one patient and one change, appealed to the teams in a very powerful way. It seemed to be a revelation to many participants, freeing them from the potential paralysis that can result from getting stuck in months of planning, education of all staff, or analysis of data, prior to actually making any changes.

So when we started the IC5 project, where predominantly it tends to start with one small change and start at the bedside type change and then move up and broader, one patient, one initiative, it was the absolute opposite from what we had been working on. Very different, very different approach. Since then we have started to take a look at that model for other projects we have done. One little thing, one little change, one little patient, start that, build a seed, grow to the flower, grow to the field, grow to the farm. So it's been a different approach for us. (Team member)

I like the PDSA model. I have in mind to train the managers on it because I like the concept that you just get in there and give it a try. You can evaluate then. I do like that concept. You don't spend months and months analyzing data. (Team leader)

While the rapid cycle thinking was a novel approach for many, some participants seemed have prior experience with the general concept, suggesting that only the “little jingle” (the PDSA acronym), was new.

Yeah, I mean I think the whole idea of coming up with an idea, trying it and standing back and evaluating it and then making a necessary change, I think that's pretty common but I think the way they had it was a little jingle [PDSA]. (Team member)

For me the PDSA was interesting. It was a framework, a concept and I was talking to somebody the other day about that the belief that it was a key ingredient. I think it was but for me intuitively and intellectually I don't see that, so when I had to stop and put it into a box or framework that was really hard because I just automatically know what I need to do to get, to achieve change. So I would intuitively do things and it wasn't until I spoke with my colleague, well that's a PDSA. Oh it is? Yes, we should write that up. Okay. Then the writing it up became an exercise to do because of the project. (Team leader)

The trap of starting small: difficulty moving beyond one patient or resident

The PDSA cycles and starting small certainly provided the teams with robust conceptual tools to craft and test changes. Some participants understood that starting small, with one patient, one idea, was simply the beginning and they appeared to recognize the need to move beyond that first patient. Setting goals, for example, ten patients by the end of the month, combined with the ongoing follow-up work of the visible body, helped move the change effort along.

Instead we'd start out with one little thing, can we do this one little thing? Can we look at prompted voiding, can we looking at getting people on scheduled toileting that couldn't do prompted voiding, can we look at trying to do this, can we look at getting a better commode in this room, getting it at the right height, getting something for communication for this patient. Then we would move to the next patient and then learn from what we had in the first patient. Okay, this is what we did in the first assessment, do the second assessment, this is what we found, how can we then, so it had to look speedier. Underscore, we had decided on a number of patients that we wanted to do with some data from MDS originally and looked at people we thought we could make some changes with, we picked a number and said this is our goal to reach by the end of the project by this month so we'll do so many and then looked at them and said okay, this looks like once a week and da da da, then we have time to do it at the end etcetera, so we had set up some goals and then okay from this one, then move on to the next. (Team member)

By contrast, others seemed to focus on single patients as case studies, in part because clinical staff identify with individual patients rather than more abstract processes. As one senior project sponsor observed, frontline staff could appreciate the difference a change made for a specific patient.

I just know that, I've attended some of their staff meetings when they presented it to the staff and then reinforced testing and that sort of thing, as they would identify a specific patient and how it made a difference for them, it was like a light coming on. I think frontline staff really equate with that because they can identify with that. So it'll take some time for them to sustain the project and their approach to it before they can show them the data. (Senior project sponsor)

Because frontline staff relate so strongly to stories of individual patients this can be a strong motivator and help build the needed buy-in for change. However, there needs to be a counterbalancing focus on process to keep the focus on the making the change part of the routine for

all patients, not just the single, one-of test cases. As noted earlier, process thinking capability may have been lacking in many teams, given that few had any specific quality improvement skills or experience.

They were all at different points, I realized that all of them clinically were there, they were getting there, it was okay, but in terms of improvement, it was like way up and down and they were really focused on the clinical side of things so they were talking about patients and case studies and some teams never got off that. Never, when we said 'process' I still say they did not get what we were saying or they got it and they didn't get it at the same time. (Coach)

One participant spoke of cycles, ramps, and applying the new practices to every new admission, indicating some movement from single patients to the process. However, she used the language in an interesting way, talking about "all these little improvement cycles *on this one man*" (my emphasis).

When I developed our presentations, I've used visually the PowerPoint to show how we did this, like we had a helicopter's view to see how this actually did ramp up with the different initiatives because I put the, for the catheter, developing the audit criteria, you know, developing the criteria for the clinical indications, to see in the audit, analyzing the audit, making the package changes, all these little improvement cycles on this one man and you can visually see that you've ramped up for this improvement and now you're thinking about every resident that comes with a catheter, you're practicing differently so you can see how each improvement was little cycles of helping. (Team leader)

Another commented that she found the concept of ramps confusing and would have liked more about the topic at the learning session. The rapid cycle methods, concepts relating to processes, and measurement for improvement are a new language for many. Frontline staff are immersed in the flow of their work tasks and the language of clinical care of individual patients, normally lacking time to step back and reflect on processes in a more abstract way. The collaborative was an opportunity to do just that. However, it seems as if all the participants were swimming in the current as hard as they could. Participating in IC5 meant that they had to keep swimming but at the same time learn synchro moves with their project

team in the river; the water is not staying still and they have little time on dry land to learn the moves or to practice together.

Discussion point: Given that the specific patient mode of thinking is so pervasive and powerful, those running collaboratives face a challenge: how to leverage the communicative power of individual case stories but provide concrete examples of how to move thinking towards multiple dots/data points for PDSA cycles and ramps of multiple PDSAs. Including even brief discussion of process mapping and analysis may help.

The value of the learning and exchange opportunities

"...it was a beautiful experience..."

IC 5 Team Leader

Participants emphasized consistently how much they valued the various learning and exchange opportunities, such as the three learning sessions and the teleconferences facilitated by the clinical and improvement experts. For many, these provided access to resources and expertise that they would not have had otherwise.

Certainly because of the support from the Toronto certainly was a major boost for us. The direction, frontline staff often commented on the learning, that they weren't just learning about how they could make continence better for patients but they were learning how to do projects so they felt proud of that. So they worked. Obviously there was support from the sessions in Toronto. It's the kind of expertise that we can't offer here unless we pull in people as consultants and then get everyone off for a full day of learning, it's really difficult. But they sure absorbed a lot while they were away. (Senior project sponsor)

To have them [the experts and coaches] available as resources, I mean they were always approachable, always responsive. (Senior project sponsor)

Well, for us it was being able to have the expertise of [clinical expert] and that was definitely a strength. I found her very approachable. She was very organized. So I found her, she has teaching skills so that was valuable. (Team leader)

I mean it was a beautiful experience, so the leadership we had in the collaborative through [experts] and [coaches]...their leadership and how they helped us at the learning sessions train and see things. [Expert]'s humour and way of engaging with us and then [other expert]'s ability to bring it down to the practicality so early on in the learning sessions when we were struggling with aim statements or PDSA's and people didn't know how to translate that. He just had a way of reframing it so that people understood. So yeah, their leadership and their contribution. (Team leader)

Many enjoyed the poster sessions and took advantage each chance to go through them with their teams, though a few found the posters overwhelming. The learning sessions, and the contact with the coaches in between, also provided structure needed to keep the teams going.

Many participants were still actively scanning the list serve messages, answering questions or passing them along to colleagues in their organizations who might be able to respond. One team member did not like the volume of messages the list serve generated and would have been happier to have all the messages routed through the team leader, but this participant appeared to be an exception.

Suggestions from participants about what could be done differently:

- Give more presentation time for the teams at the learning sessions.
- A couple of the days were really, really long; perhaps end before 5:00.
- Focus poster presentations more clearly on problems and solutions.
- Provide opportunities for the team leaders to meet together to talk about challenges.
- Provide opportunities for clinical disciplines to meet together.
- Teams should give more progress updates, e.g., in teleconferences.
- Compile a binder or resource kit of ideas (tips and techniques) for how to make the changes; e.g., collect examples of the quizzes and cross word puzzles prepared by some teams.
- "Nothing. I think they did a good job."

Discussion point: Participants were worried about losing the access to these resources when the project formally ended. Several wanted some form of structured support continue, for example the list serve or even follow-up teleconferences to discuss results and issues related to sustaining changes. Some form of continued support for teams, if feasible, should be discussed when planning the project and with participants.

The coaching role and coaching challenges

"...It's the coach that kept you going...having the coaches was extremely valuable."

Senior Project Sponsor

The participants spoke at length of their appreciation for the role the coaches played. The coaches kept the teams on track, helped them to solve problems, answered questions or found someone who could.

I just feeling I'm not articulating enough the importance of the support that they got from the project because I know that [coach's] name came up frequently. That gave us enough structure that they always knew where they were headed in the project, so the learning with that personal contact wouldn't be something you could achieve by just sending paper content out to them every month. That personal contact was really important. (Senior project sponsor)

I think the other thing that they did which other collaboratives I've been in haven't done is have a coach assigned and dedicated to you. To be quite honest, it's the coach that kept you going because in a year's time, it is a short time but so many other competing priorities come and knowing that your coach is going to be calling you next week to find out where you're at or that there's a session coming and the coach is after you to get your slides or to get your poster or to get whatever made you stay on track and kept this a priority because it would have been very easy several times throughout the year to just say oh well, we didn't have time, we didn't have time or let it slip so having the coaches that really were there as task masters in a way but also they were there to help you problem solve. Or they'd ask those probing questions. They challenged why are you doing it like this? Have you thought of measuring like that? Or you know what, I don't know, I'll get an answer for you and I'll get back to you. So they saved you a lot of running around and having to ask three or four people. They would get the information for you and come back to you. So having the coaches was extremely valuable. (Senior project sponsor)

I mean the one thing that was really good is with having the leaders like [coach]. You had a contact person that was excellent, that you know who to contact, what questions. They were very good at responding. (Team member)

[Coach] was definitely very organized. You knew what you had to do when you left and you had a resource to contact with questions. The contacts keep you going. (Team leader)

Communication, contact, keeping teams on track

As the participants noted, the coaches were communicators who provided guidance by listening and asking constructive questions. One coach described the role and skills set required.

With the communication, I think you need as a coach, so being a good listener, being a good communicator and out of that comes being able to guide your team so helping them to be able to prioritize. Keeping them on track with what stage of the collaborative they're at, whether it's in the early stages, developing their aim statement, that sort of thing or whether it's even later on trying to spread it beyond the first unit that they worked on so that was very much later in the stage of the collaborative and then of course there's all sort of things in between there such as measuring and taking one PDSA and going to the next and that sort of thing. So certainly being able to guide your team at the various stages, helping them prioritize....Helping them to learn from mistakes and helping them to share then, on the other side of the coin, to share in their successes and successes can be really small things but if one recognizes something that's successful, I think it helps to motivate the team on to bigger and better things so little successes can be really important. (Coach)

In addition, it took time to get to know the teams that they were assigned, to understand how they were functioning, and what kind of contact would work best for each. As another coach noted, "I was a very different coach for each team, it took me some time to figure out how to be the right kind of coach for different teams." Consequently, the nature of the contact changed over the course of the project.

I always thought okay, what should we be asking for? How often should I be bugging them by e-mail? Then it was also who should I be bugging? Teams were different. Until I understood that the team leader on one of my teams was actually not the day to day leader and had no idea what was going on in the unit. On a second team, the team leader was a day to day leader and knew what was going on in the unit. On the third I knew I had to be 'ccing' a couple of people and that takes time....As we got to the end, they would call me back and there were fewer communications, I probably got smarter about how to reach them. I wasn't very smart about how to reach them in the beginning because either I wasn't contacting them or I was barraging them. Just about when to contact them, about who to contact and what I was asking for. I was asking if they needed anything versus here's what we expect. (Coach)

Motivational coach rather than a quality coach?

The coaches also provided morale support and a sympathetic ear. Often, they were “motivational coaches rather than quality coaches,” as one coach described it, spending more time helping with the interpersonal aspects of change management than they did with the technical aspects of improvement. One of the team leaders talked at length about the helpful dialogue she often had with her team’s coach.

One of the biggest learning’s for me was my coach, [coach]. I learned what it was like to have a coach. She was great. So if I was frustrated and having a bad time, I could talk to her and express my frustrations and it was great because she was external and that was really good for me. But I’m also a very verbal, articulate person and sometimes the opportunity to do that, to have that dialogue or discussion enables the person themselves to discover what’s going to work and what is not going to work and you don’t need somebody else to tell you but [coach] had a way of asking a question that would make you think about well what do you think is going to work? So the opportunity of having that dialogue and some strategies and techniques that she suggested to me were helpful. I really valued that. (Team leader)

It was evident that the coaches provided a good deal of emotional and problem-solving support for team leaders and some team members who ran into resistance, complex team dynamics, or other frustrations in their organizations. This could be time-consuming, challenging work.

The other difficulties I encountered were my own learning curve. As [experts] were teaching us, I was learning. So here I am trying to coach teams and at the same time I’m being coached so I just went with the fact that I was learning as they were learning. I think I expected that I would have more time to do this and that I wouldn’t be stumped so much by some of the issues. I felt stumped a lot. It wasn’t just the PDSA issues, the questions I was being asked had to do with team dynamics, had to do with just stuff about fitting this into their schedule, going from small ‘t’ to big ‘T’, like their little team to the bigger team. I felt stumped several times and you know sometimes I just expected I would have the answers. (Coach)

Challenges

The complexity of the coaches job was influenced by all the issues touched on in the previous

sections of this report. Because many teams experienced frustrations at various points and there appeared to be little improvement support available to most teams in their organizations, the coaches stepped in to help. The coaches had both an in-depth immersion in and a bird's-eye view of the challenges. This is reflected in the mix of things they said should be done differently next time:

- Do more to ensure the senior leaders understand the resources required and that they are prepared to commit those resources to support the teams.
- Do more frequent sight visits to each organization.
- Hold on-site workshops for staff in the organizations.
- Have more intensive involvement with all teams.
- Set aims and measures for the teams at the start.
- Build in more time for learning and discussion sessions together; “some of the best conversations we had were over lunch with [improvement expert] and we should have done more of that.”
- Clarify role expectations early.

Discussion point: It is interesting to consider what the role of the coaches *should* be. The support they provided could be very labour-intensive; would they have been able to do the same if there were more than a dozen teams? Given how the teams were formed and the organizational contexts in which they worked, many required fairly intensive support. What level of support is reasonable for the teams to expect? What level is feasible to provide? The title "coach" implies a fair amount of contact and direct facilitation with the teams or at least the team leaders. In fact, the coaches sometimes acted as personal coaches for the team leaders. At what point is it a full-time job to provide that level of contact and support - when coaching four teams? Five?

A specific job description would perhaps help role clarity and could be shared with teams.

Spreading the changes

"...How can we start with the kernel, the seed and grow up from there?"

IC 5 Team Member

Given earlier descriptions of their enthusiasm, it is not surprising to note that participants said that PDSA as a change management method has spread in their organizations, more so than the actual changes they tried to make in continence care. "Yes, like I said, the PDSA cycle is talked about everywhere."

I think from the organization what it's done for us is allowed us to explore perhaps different ways of moving large scale initiatives, even within our own organization so what we've learned from being part of this collaborative, we can now take on a much smaller scale within the organization because if you think about it, often when we're moving a big initiative forward, it is a collaborative in that the finance department is collaborating with the supplies department and purchasing department is collaborating with the clinical department. You can imagine that each department is like a whole other organization in and of itself; we've been able to take that learning from the IC5 project and implement it internally and so I've got people talking about rapid cycle improvement even within the organization and people are starting to adopt that as a methodology for doing things even internally. They've been interested in asking people like [TM 3 T5], for example, who sits in the risk management and QI department to come and present and show us how to do this because we've been able to demonstrate that it works. (Senior project sponsor)

The concept has worked in terms of how we're going to approach other educational projects and we've taken the idea of the PDSA cycles and starting with that concept with a couple of other projects we're looking at as well with some of our wound care things and how we're going to do patient and family education for skin care for example. We're kind of taking that same approach. How can we start with the kernel, the seed and grow up from there? (Team member)

In a few instances, both the clinical process improvement has been sustained and the improvement methods are spreading, "because now we know how to do it," as one senior project leader said with pride.

Senior Leader: Oh they've continued. They monitor their patients all the time. They have tools that are quite extensive as far as the work that they've done with the clients on that particular unit. They've presented to the Nursing Advisory

Committee and they've approached several other directors from other units as to what unit they can use it on next. They've been in touch with a long term care facility and offered their team as a resource. They've prided themselves on the presentations they've made on various venues. I feel like I'm missing one. Oh, Community Care Access Centre, they've also offered to educate them on the process they're using because they'd like to see it extended into the home.

AM: Oh very good. So it sounds like a combination of the specific clinical content about incontinence care as well as the improvement knowledge or the project knowledge?

Senior Leader: The project knowledge, they keep trying to perfect this particular project because they're so afraid of letting it slip, but on their agenda is which project can we do next, because now we know how to do it.

In one organization the continence care information has been presented and discussed more so than the improvement methods, which have not spread.

No, I think that's the next, I think we need to create opportunities to talk more about the methodology. We've talked about the content, we haven't talked about the methodology. We need to do more of that. So no, we've not used that component on other teams. (Senior project sponsor)

Difficulty sustaining the changes

"...it would be helpful to have support for planning sustainability early on...it needs to be something right from the beginning..."

Senior Project Sponsor

The challenge of trying to sustain changes came up repeatedly. Many participants were concerned that they could not keep the momentum going and the changes had not yet taken root or "soaked into the culture" in the context of bigger organizational changes.

It's gone because you need that, everybody is so busy in keeping their head above water sort of thing. It's because the whole model, everything has changed, the patient acuity has changed so people are still in that change mode or dealing with that major change so to start, yes, I know this is a small change but to get them really into it, they're still struggling with the other big changes so until they get, the culture gets changed and that part gets done, you're adding more changes. It's like I just, they don't even want to hear it. [Team member]

As noted earlier, the reliance on few day-to-day change champions - combined with the difficulty of moving beyond the one-patient focus - made the change efforts fragile. One senior project sponsor emphasized that it takes years for change to become routinized.

Well I think in terms of evaluating change is the notion of incremental improvements and giving enough time for change practices to become part of what I call routinization, like to be imbedded. So I think that it would be great to be able to evaluate this further out in terms of the impact and the sustainability. I think it would be helpful to have support for planning for sustainability early on. I think it needs to be something right from the beginning. There were a lot of supports during the project and I think this offering up to continue the web page and to continue the list serve is really important because I think the networking really helps because it's longer than a year like I found with any of the best practice guidelines, it's a multi-year effort. You'll see the trends and improvements over a number of years so I think in the very initial evaluation or formal evaluation, I anticipate they're going to see just incremental change and they might feel discouraged that so much was invested in this. [Senior project sponsor]

But they are willing to do it all again!

For all the challenges and obstacles the teams experienced, participants clearly thought the benefits far outweighed the personal and organizational costs of the time and effort they invested.

AM: *“Do you think your organization would join an improvement collaborative again, if you had the opportunity?”*

Team Leader: *“Yes, we would. I’m hoping there’s another one. Is there another one?”*

APPENDICES

Appendix A. Description of methods

Semi-structured interviews were carried out with sixteen individuals: thirteen (the team leader, team members, and/or a senior administrator who sponsored the team) in each of five participating organizations, as well as the three project coaches. The organizations were selected based on input from the IC5 project team with the goal of maximizing diversity of experience. Selecting a purposeful sample of organizations allowed for a range of successful to less successful teams to be included. Invitations to participate were sent to 22 individuals in the five organizations and 13 accepted.

Fifteen interviews were conducted in-person and one by telephone, using semi-structured interview guides (see Appendices B-D). Written consent was obtained from each participant. The open-ended questions were designed to elicit participants' experiences with quality improvement and with the project, including their views on what worked, problems encountered, strengths and weaknesses of the collaborative model, significant learning, and potential for spread of the improvement model within their organization. The interviews ranged from approximately 40 to 90 minutes in length and were taped (with permission). The tapes were transcribed and the transcripts downloaded to qualitative analysis software (ATLAS.ti) for data management purposes. Transcripts were coded and analyzed using a constant comparative method to identify key themes.

Appendix B: Interview Guide: Team leaders and members

FOCUS OR TOPIC	INTERVIEW QUESTIONS
Brief recap of study topic and purpose	<p>[I will briefly reiterate this information from the study overview/explanation which participants will have been given earlier with the consent form.] My aim in this interview is to learn about your experience participating in the IC5 Collaborative. Do you have any questions before we begin?</p>
Participant's role and responsibilities	<p>I'd like to start by asking a bit about you and your role. - How long have you been with [organization]? - what are your responsibilities - Did you have experience with quality improvement before the IC5 project? [If yes, probe for what, when]</p>
Involvement in IC5	<p>How did you get involved with the IC5 project? What was it like working on the project? - [probe for how it compared with prior QI experiences, if any] - How was your team organized? - [probe for how did the work get done, by whom] How resource-intensive was the project for your team? - [probe to find out if this was a surprise]</p>
What worked	<p>What do you think worked well about your IC5 project? - Why?</p>
Problems encountered	<p>What kinds of problems did you encounter during the project? - Were you able to resolve them? [If yes, how; if not, why not] What would you do differently next time? [Any suggestions for the HRRC team?]</p>
Communication with other staff	<p>Have you communicated with others at [organization] about the project? - [probe for any education materials, presentations, or sessions] What has the response been like?</p>
Learning	<p>What do you think are the strengths (if any) of the Collaborative model? What do you think are the weaknesses (if any) of the model? What was the most significant thing you learned from your experience with the IC5 Collaborative? Do you think that you will use this approach to quality improvement again in your organization? [If yes, why; if not, why not]</p>
End interview	<p>[Draw interview to close, with thanks and ask permission to contact participant for clarifications, if any.]</p>

Appendix C: Interview Guide: Senior Administrator/ Project Sponsor

FOCUS OR TOPIC	INTERVIEW QUESTIONS
Brief recap of study topic and purpose	[I will briefly reiterate this information from the study overview/explanation which participants will have been given earlier with the consent form.] My aim in this interview is to learn about your organization's experience participating in the IC5 Collaborative. Do you have any questions before we begin?
Participant's role and responsibilities	I'd like to start by asking a bit about you and your role. - How long have you been with [organization]? - what are your responsibilities - Did your organization have experience with quality improvement before the IC5 project? [If yes, probe for what, when]
Involvement in IC5	How did [organization] get involved with the IC5 project? What was the project like for [organization]? - [probe for how it compared with prior QI experiences, if any] - How was your team selected and organized? - [probe for how decisions about this were made] How resource-intensive was the project for your organization? - [probe to find out if this was a surprise]
What worked	What do you think worked well about [organization's] IC5 project? - Why?
Problems encountered	What kinds of problems did you encounter during the project? - Were you able to resolve them? [If yes, how; if not, why not] What would you do differently next time? [Any suggestions for the HRRC team?]
Communication with other staff	Have you communicated with others at [organization] about the project? - [probe for any education materials, presentations, or sessions] What has the response been like?
Learning	What do you think are the strengths (if any) of the Collaborative model? What do you think are the weaknesses (if any) of the model? What was the most significant thing you learned from your team's experience with the IC5 Collaborative? Do you think that you will use this approach to quality improvement again in [organization]? [If yes, why; if not, why not]
End interview	[Draw interview to close, with thanks and ask permission to contact participant for clarifications, if any.]

Appendix D: Interview Guide: Coaches

FOCUS OR TOPIC	INTERVIEW QUESTIONS
Brief recap of study topic and purpose	<p>[I will briefly reiterate this information from the study overview/explanation which participants will have been given earlier with the consent form.] My aim in this interview is to learn about your experience participating in the IC5 Collaborative. Do you have any questions before we begin?</p>
Participant's role and responsibilities	<p>I'd like to start by asking a bit about you and your role. - [what are your responsibilities] Did you have experience with quality improvement before the IC5 project? [If yes, probe for what, when]</p>
Involvement in IC5	<p>How did you get involved with the IC5 project? What was it like working on the project? - [probe for how it compared with prior QI experiences, if any]</p>
Working with the teams	<p>How were your teams organized? - [probe for how did the work get done, by whom] What was the frequency and duration of your contact with the teams? - What sorts of issues did they bring to you? How resource-intensive do you think the project was for the teams? - [probe to see if this was surprise]</p>
What worked	<p>What do you think worked well about with the IC5 project? - Why?</p>
Problems encountered	<p>What kinds of problems did you encounter during the project? - How were you able to resolve them? [If not, why not] What would you do differently next time?</p>
Learning	<p>What do you think are the strengths (if any) of the Collaborative model? What do you think are the weaknesses (if any) of the model? What was the most significant thing you learned from your experience with the IC5 Collaborative? Would you recommend this approach to quality improvement to organizations? [If yes, why; if not, why not]</p>
End interview	<p>[Draw interview to close, with thanks and ask permission to contact participant for clarifications, if any.]</p>