

TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development,
Implementation Science, and Evaluation



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SCALING UP AND OUT: SYSTEM-WIDE IMPLEMENTATION INITIATIVES

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify the key factors that influence scaling up and out of evidence-based practices, and why each is important in creating sustained change
- Understand the multifaceted strategies that have been utilized to achieve system-wide engagement in evidence-based practice as illustrated through three case studies highlighting RNAO implementation initiatives
- Describe the role of RNAO's evidence-based guidelines in scaling activities within nursing, the healthcare system, and beyond
- Gain appreciation for the role of Champions knowledgeable about change and spread processes as well as about the content of the change
- Outline how partnerships can be leveraged to scale out to increase exposure and scale up to influence policy
- Define how leadership at all levels can impact scaling up and out of innovations
- Express how delivery of the innovation through building networks, developing capacity, adapting to local context, and integrating with the current system impact scaling up, scaling out, and scaling deep

INTRODUCTION

Using diffusion theory that reflects principles of scaling up and scaling out, this chapter outlines key factors that influence the successful spread of evidence-based practices, education, and policy from organizational to regional, provincial, and national levels, with impact on all sectors. The three case studies presented illustrate RNAO's use of these principles in selected implementation projects, focused on mental health and addiction, smoking cessation, and falls prevention initiatives and the resulting effect on sustained practice and policy changes. Specifically, a systematic spread methodology; access to clear, credible, evidence-based resources known to be effective; identification of related implementation enablers; capacity development; and engagement of administrative and clinical leaders and collaboration with partners all contribute to the effective scaling up and out of evidence in practice, leading to sustained use across levels and in all sectors of the health system.

SCALING: THE GOAL OF DIFFUSION AND INNOVATION

Over the last decade there has been growth in the implementation literature exploring how practice innovations can be deliberately spread across the system to enhance health outcomes. In part, this is due to an increasing recognition that despite the development of innovative products, practices, and programs within the system, they have not always achieved their full impact due to challenges with scaling up (Mangham & Hanson, 2010). Much of the emerging research in the area of scaling up is focused on public health interventions and large-scale global health programs, and there are many definitions of scaling up in the literature. However, common elements include a description of *scaling up* as a series of processes to introduce innovations with demonstrated effectiveness and with the aim of improving coverage and equitable access to the innovation(s) (Edwards, 2010).

In the health sector, *scaling up* has been defined in some cases to mean expanding coverage of an intervention (Mangham & Hanson, 2010) and in other cases to mean “efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis” (Simmons, Fajans, & Ghiron, 2007, p. viii). This latter definition reflects the typology to scaling presented by Moore and Riddell (2015) and includes *scaling up* (expanding coverage), *scaling out* (altering the policies, laws, and standards), and *scaling deep* (changing the norms). In order to maximize benefits from implementation efforts, it is critically important to consider all three aspects of scaling when diffusing innovations. In this chapter, we differentiate amongst scaling up, out, and deep, where it is important to emphasize specific activities targeted to expansion, policy impact, and sustainment.

SCALING UP: KEY CONSIDERATIONS

Edwards (2010, p. 12) explored the elements that affect the scale-up of programs through examining both effective and ineffective scaling up experiences. The challenges identified in ineffective initiatives can be grouped into six categories:

- Underestimating the resources required for scaling up
- Political and policy naivety
- Lack of attention to issues of sustainability and scaling up during early efforts to test or implement innovation uptake
- An over-emphasis on either the vertical or the horizontal spread of innovations
- Inattention to spatial elements of scaling up
- Inattention to the demand side of scaling up

Edwards (2010) put forward a typology for innovations relevant to public health practice according to their potential for scaling up. She classified these innovations as: 1) discrete innovations; 2) mixed component and multilevel innovations; and 3) paradigmatic innovations. *Discrete interventions* are those that are well-defined and have also been referred to as direct interventions (Policy Brief, 2010). They are considered for scale-up because their efficacy and effectiveness have been demonstrated, and their implementation initially appears to be straightforward. Some examples of this type of innovation within public health include vaccinations and micronutrient fortification and fluoride in drinking water.

The second category—mixed component and multilevel innovations—involves many interrelated components (intersecting set of innovations) that are targeted at more than one system level. These innovations tend to be more complex, less prescriptive, less structured, and have components that must work synergistically to achieve the intended benefits. Components of these interventions need to be adapted to both the target population and the context in which they are being introduced, while maintaining the elements of the intervention that have proven to be effective. In addition, elements of these innovations may diffuse organically, for example, through a social movement. Examples of this type of innovation are seen in the fields of tobacco control, heart health, childhood obesity prevention, and workplace safety (Edwards, 2010, p. 9).

The final category described by Edwards (2010) is paradigmatic innovations. These innovations involve a new way of thinking about issues, how we understand them, what might be possible solutions, and who should be involved in determining and implementing the solutions. Examples include utilizing a social determinants of health lens in an upstream approach to programs and considering health in all policies in an effort to achieve population health. This typology of innovations helps those working to scale up programs to consider the features of the innovation and the factors that may impact on the scaling up process. In some ways this innovations typology is akin to the scaling typology—scaling up, out, and deep (Moore & Riddell, 2015)—with the exception that Moore and Riddell assert that in all scaling initiatives, regardless of size, cultural impact is critical to make them stick. In other words, the deeper the scaling, the better.

SCALING UP SUCCESSFULLY

In determining how best to approach scaling of an innovation, Yamey (2011) offers a useful framework based on a review of the literature, personal experiences, and the experiences of “scale-up experts” in the global development field. Through this examination of key themes in the emerging science of large-scale change in global health, Yamey (2011) identified the following factors that explain successful scale-up:

- **Attributes of the intervention**—Recognized as valuable, easy to use, and evidence-based
- **Leadership and governance**—Involve leadership at all levels and foster commitment to scaling up and out
- **Get buy-in**—The adopters engage a range of key stakeholders and implementers in the target community
- **Delivery strategy**—Tailor the scale-up approach to the local community, using diffusion and social network theories, cascade and phased approaches, adaptation to the local context, and integration into the local system
- **Measurement and evaluation**—Build in evaluation and incorporate lessons learned

The three case studies that follow illustrate many aspects of both the Edwards (2010) typology of innovations and the typology of scaling by Moore and Riddell (2015) and demonstrate how the elements of Yamey’s (2011) scaling framework were addressed to ensure success. The innovations being scaled up in these implementation projects all fall within the mixed component and multilevel category, founded on evidence-based practices proven to be effective, as synthesized in the relevant RNAO BPGs. The approaches to scaling reflect scaling up, scaling out, and scaling deep through the multiple methods used and the degree of community engagement. In addition, many of Yamey’s (2011) themes will be evident in unique ways in each of these examples of scaling up initiatives and highlighted as to their impact.

C A S E S T U D Y

MENTAL HEALTH AND ADDICTION INITIATIVE

The Ontario Ministry of Health and Long-Term Care’s (Ministry) Methadone Task Force was established in April 2006 in response to an increase in opioid prescribing and misuse and the need for accessible, equitable, and timely Methadone Maintenance Treatment (MMT) services for opioid addiction in Ontario. Following extensive deliberation by the Task Force based on expert, scientific, and experiential evidence, the report was released in 2007 (Ministry of Health and Long-Term Care [MOHLTC], 2007). It included 26 recommendations addressing nursing and other healthcare disciplines and outlined elements necessary for accessible, comprehensive, and integrated MMT services in Ontario. Subsequently, the RNAO was funded to develop a Best Practice Guideline entitled *Supporting Clients on Methadone Maintenance Treatment* (RNAO, 2009b) and to support its uptake through awareness raising, education, and capacity building. This was in response to one of the report’s recommendations directed toward RNAO due to its strong reputation for excellence in the area of policy and evidence-based practice guideline development, dissemination, and evaluation.

Following RNAO’s publication of the guideline in 2009, the guideline development Expert Panel identified the need for additional guidelines and resources for nurses and other healthcare providers to effectively support Ontarians with mental health and addiction needs. Through continued advocacy for this population, RNAO received additional funding from the Ministry and launched the RNAO Mental Health and Addiction Initiative (the “Initiative”) in 2010. Since then, the Initiative has served as a key resource in Ontario to support nurses and other healthcare providers in effectively working with people who use substances and need assistance with mental health.

SYSTEMATIC IMPLEMENTATION METHODOLOGY

In 2013, to better understand the needs and gaps within the Mental Health and Addiction system, RNAO sponsored an in-depth environmental scan to inform the development of a 5-year comprehensive strategy to guide the work of the Initiative. The findings from the scan

concluded that nurses needed support in all sectors and across the continuum of care that could be addressed through implementation of guidelines specific to mental health and addiction. Other priorities in mental health and addiction included strengthening the practice/policy interface with BPG development and uptake, enhancing capacity in nurses through undergraduate nursing programs across Canada and professional development opportunities, and developing evidence-based resources for nurses and other health disciplines to support their practice.

RNAO crafted a conceptual model (see Figure 10.1) that provides direction for the systematic implementation methodology utilized by the Initiative to spread and scale up addiction and mental health best practices. The Initiative incorporates the key elements of access to evidence-based guidelines and implementation supports; capacity building related to knowledge, skills, and attitudes; and collaboration with partners and supportive stakeholders to aid in scaling up, out, and deep.

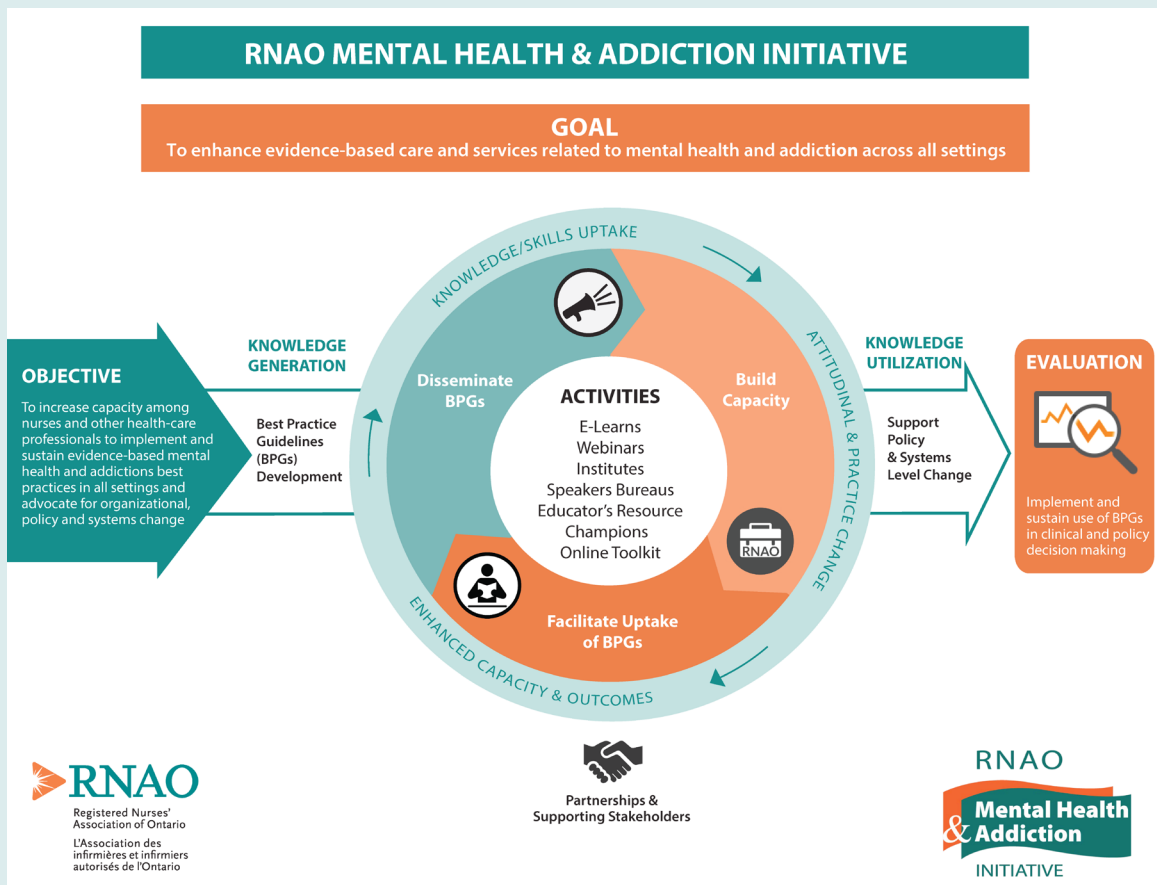


FIGURE 10.1 RNAO Mental Health and Addiction Initiative conceptual model.
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ACCESS TO EVIDENCE-BASED TOOLS (DISSEMINATION OF BPGS AND IMPLEMENTATION RESOURCES)

RNAO has over 15 years of experience developing Best Practice Guidelines and supporting effective dissemination and knowledge uptake at the practice, education, and policy levels. To date, multiple BPGs have been used to impact system-level change related to mental health and addiction. For example, the practice recommendations contained in the guideline *Engaging Clients Who Use Substances* (RNAO, 2015a) form the core curriculum for all RNAO professional development programs related to addiction. The education recommendations from this BPG, along with those from the following BPGs with a mental health and addiction focus—*Person- and Family-Centred Care* (RNAO, 2015b); *Establishing Therapeutic Relationships* (RNAO, 2006a); *Facilitating Client Centred Learning* (RNAO, 2012a); *Crisis Intervention* (RNAO, 2006b); and *Enhancing Healthy Adolescent Development* (RNAO, 2010a)—supported RNAO’s work with the Canadian Association of Schools of Nursing (CASN) and faculty across Canada in the development of Entry-to-Practice Mental Health and Addiction Competencies. Moreover, the policy recommendations inform RNAO’s advocacy work related to harm reduction, decreasing health inequities, and provision of improved access to integrated and collaborative care for clients who use substances. All the above-mentioned BPGs as well as others focused on mental health and addiction—such as *Interventions for Postpartum Depression* (RNAO, 2005a); *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour* (RNAO, 2009a); and *Woman Abuse: Screening, Identification and Initial Response* (RNAO, 2012c)—have been used to inform capacity building and practice, education, and policy initiatives.

The Mental Health and Addiction home page on the RNAO site (www.RNAO.ca/mentalhealth) serves as a one-stop shop for nurses, other healthcare providers, and the public to access the many evidence-based resources developed by RNAO and provided to promote knowledge

translation and exchange at the provincial, national, and international level. These resources include: self-directed e-Learning modules, educational videos, a Youth Mental Health and Addiction Champion (YMHAC) Toolkit (which supports mental health promotion and resiliency amongst youth), educator guides (to support best practices consistent with mental health and addiction core competencies), regular knowledge-exchange webinars, nursing order sets (technology-enabled implementation supports), decision trees, and “pocket guides” as reminder prompts to support BPG implementation. Various other communication channels targeted to local, national, and international stakeholders are used to support dissemination, including partnerships, social media, presentations, publications, and mental health campaigns such as the Canada-wide Bell Let’s Talk (Bell Canada, 2017).

CAPACITY DEVELOPMENT

Given the prevalence of mental illness across the age spectrum and the relationships amongst mental health, illness, addiction, and other related conditions, it is assured that nurses in all practice settings will care for clients with mental health and illness challenges (Nadler-Moodie, 2010). The Initiative builds capacity amongst nurses to utilize evidence-based best practices and tools when working with individuals with needs in mental health and addiction.

UNDERGRADUATE NURSING PROGRAMS

A key priority for the Initiative, in partnership with the Canadian Federation of Mental Health Nurses (CFMHN), is to support faculty to ensure the undergraduate nursing curriculum provides an integrated focus on evidence-based addiction and mental health content. The intent is to enhance students’ ability to address mental health and addiction needs with clients in all settings.

Related to this priority, RNAO worked with CASN and other national stakeholders in developing a national consensus-based framework of essential discipline-specific entry-to-practice mental health and addiction competencies and indicators, which were published by CASN

in 2015 as the *Entry-to-Practice Mental Health Competencies for Undergraduate Nursing Education in Canada* (CASN, 2015). The competencies ensure integration of core content related to mental health and addiction into nursing curriculum and are used by CASN along with other competencies and standards when accrediting schools of nursing.

RNAO was also engaged in a partnership with CASN to determine strategies to disseminate the competencies and ensure their uptake. This resulted in collaboration in the development of the *RNAO Nurse Educator Mental Health and Addiction Resource* (RNAO, 2017a) endorsed by CASN and mapped against the CASN mental health and addiction competencies. The document is available in hard copy and online and has been disseminated to schools of nursing across Canada. Multistakeholder capacity-building events and supports have been established to facilitate uptake of this valuable resource.

ENGAGEMENT OF CHAMPIONS

As discussed in Chapter 4, *Forging the Way With Implementation Science*, RNAO has invested in the training, engagement, and mobilization of Best Practice Champions. As a key strategy within this Initiative, a tailored Champions program has been established to address not only the principles of implementing practice change, but also clinical content related to mental health and addiction. To date, the program has trained over 1,400 nurses and other healthcare providers to lead the uptake of evidence-based practices in this clinical area. To support ongoing capacity development for these Champions, RNAO partners with other local and national stakeholders to provide monthly webinars on topics relevant to the field, which have a wide reach locally, nationally, and internationally.

A unique application of the Champions approach in the MHA Initiative is evident in the RNAO Youth Mental Health and Addiction Champions (YMHAC) program. It is an innovative and empowering strategy for creating awareness amongst youth about mental health, illness,

and substance use. This program utilizes elements of the Best Practice Champions Network and has been conceptualized as peer-led, multicomponent, and involving multistakeholders.

In the YMHAC program, building on the principle of peer leadership, youth leaders work with their local public health unit, district school boards, and schools to mentor youth Champions in planning, delivering, and evaluating local engagement strategies. The program helps shift attitudes from a focus on mental illness toward mental health promotion, and also draws on the strength of nurses and educators working in partnership with youth to create positive, resilient school communities.

The overwhelming success of the initiative, from 2013 to 2015, was enabled by RNAO's collaborative leadership; provision of evidence-based BPGs and implementation strategies; and the partnerships that were nurtured amongst RNAO, public health, school boards, and school mental health and staff supports. To foster sustainment following the project timeframe, RNAO created the YMHAC Toolkit (<http://ymhac.rnao.ca>) in English and French and is working with key stakeholders in education and health to enable widespread implementation of the YMHAC program across schools in Ontario communities.

COLLABORATIVE PARTNERSHIPS

The Initiative is based on a collaborative approach that engages partners (nursing and healthcare stakeholders) committed to the goal of enhancing mental health and addiction services and improving outcomes. Partners that influence practice, policy, and education change include government at the policy and special program levels, the public health system and education systems, mental health nurse special interest groups at the national and local levels, and national standard setting bodies. These partnerships within and beyond the health sector are vital to the Initiative, in particular to the scaling out and scaling deep of the RNAO BPGs for MHA. Partnerships not already highlighted are outlined in Table 10.1.

TABLE 10.1 COLLABORATIVE PARTNERSHIPS AND RELATED ACTIVITIES IN THE MHA INITIATIVE

PARTNER	PARTNERSHIP ACTIVITIES
Ministry of Health and Long-Term Care (MOHLTC)	<p>RNAO has provided input and support to Ontario's 10-year mental health and addiction strategy, entitled <i>Open Minds, Healthy Minds</i>, through various consultations.</p> <p>RNAO supported related initiatives such as the need for specialized Mental Health and Addiction Nurses working in schools across Ontario; bolstering province-wide training with RNAO-led Institutes; promoting networking and partnership of nurses with other professionals (such as the school mental health ASSIST leads and integration with public health nurses); and also actively participating on the Ministry's Mental Health and Addiction Nurse Reference Group to further the expansion and sustainability of the nurses' role.</p>
Provincial Opiate Workgroup (POWG)	<p>RNAO is an active member of the Ontario POWG, a group of Ministry-funded agencies and initiatives that work toward reducing duplication of services, increasing knowledge exchange, and streamlining collaboration on various initiatives. Through this workgroup, RNAO has partnered with Centre for Addiction and Mental Health (CAMH) and the Ontario Pharmacy Association to conduct monthly webinars on emerging topics in the area of addiction, including the release of Naloxone for mass distribution.</p>
Ontario Coalition for Child and Youth Mental Health	<p>This coalition consists of education, social service, health, and justice-based organizations and works diligently to advocate for better child and youth mental health services. Through its involvement with the YMHAC program and this coalition, the Initiative has been able to meet with various Ministries to advocate for strengthening mental health care and education systems.</p>
Specialty Nursing Interest Groups	<p>RNAO leverages the expertise and experiences of its Mental Health Nurses Interest Group and Ontario Correctional Nurses Interest Group to learn about gaps in services and potential opportunities to inform their advocacy efforts.</p>
Canadian Centre on Substance Use and Addiction (CCSA)	<p>RNAO also partners with CCSA, a national organization that provides leadership on these issues in Canada. RNAO and CCSA have collaborated on a number of activities to raise awareness and gain a deeper understanding of matters pertaining to substance use.</p>

SUMMARY

Key overall impacts of the Initiative include:

- Mental Health and Addiction (MH&A) has a higher priority on the Ontario Health Agenda
- Spread of Best Practice Guidelines to secondary education with the YMHAC Program
- Spread of Best Practice Guidelines to post-secondary education with the collaboration at the national level related to entry-to-practice mental health and addiction competencies and related tools for faculty

- Enhanced focus on youth mental health and addiction in public health
- Increased capacity of nurses and other clinicians in MH&A care and service
- Reduced stigma related to MH&A in both the education and health sectors

A number of aspects of scaling up, out, and deep have been demonstrated through this case study:

- The Initiative enables scaling up by extending the BPGs and their uptake into the area of Mental Health and Addiction, influencing practice,

education, and policy and extending into the education sector, involving nonclinicians.

- The capacity-building focus contributes to scaling up and scaling deep, in particular for clinicians in relation to mental health and addiction practice changes.
- The engagement of Champions demonstrates use of a diffusion and network strategy in the spread of best practices.
- The nature of the Champions program and network targeted to youth in the school system influenced changes in attitudes about mental health.

- Engagement of stakeholders as partners in all aspects of the program has enabled sustained spread or scaling deep.

REFLECTION

What impact do you think engagement of Champions had on the scaling up of this work in clinical practice and undergraduate nursing education? How might the outcomes have been different without the targeted development of capacity in Champions?

C A S E S T U D Y

TOBACCO INTERVENTION INITIATIVE

The RNAO Tobacco Intervention (TI) Initiative is a prime example of how scaling up and out can be achieved with the right vision, plan, resources, and strategies. The vision for the TI Initiative was conceptualized in 2008 as a way to help Ontarians stop tobacco use by leveraging RNAO's BPGs and the leadership of public health nurses to support clients on their quit journey. This vision shaped the Initiative's goals, which include:

- Support the role of nurses working in a variety of healthcare settings across Ontario to reduce the prevalence of tobacco use amongst all Ontarians and increase the number of smokers who quit
- Promote the role of public health nurses (PHN) as leaders in the area of tobacco control and reduce the of the number of Ontarians who smoke by utilizing TI best practices to increase TI capacity in nurses and other healthcare workers, and stimulate organizational policy change
- Build, strengthen, and support nursing capacity across a variety of healthcare sectors to utilize TI best practices through knowledge transfer, knowledge exchange, role-modeling, and mentoring as supported by a TI Champions Network
- Maximize initiative outcomes through strengthening and building partnerships and working in collaboration with key nursing and other healthcare stakeholders, organizations, groups, and initiatives focused on tobacco cessation locally, provincially, and nationally

Based on these goals, since 2008, RNAO has partnered with the Ontario Ministry of Health and Long-Term Care and other members of the Tobacco Free Ontario collaborative to facilitate spread of BPGs in all healthcare sectors. RNAO's role focuses on its specific TI BPG-implementation activities targeted to nurses (and other healthcare professionals and organizations) to impact spread. The RNAO TI Initiative has grown exponentially over the past 10 years; however, at its core remain the evidence-based recommendations from the BPG *Integrating Smoking Cessation into Daily Nursing Practice* (RNAO, 2007) and more recently the revised guideline *Integrating Tobacco Interventions into Daily Practice* (2017b). The TI Initiative utilizes a multipronged approach to support a systematic implementation methodology. Each prong represents a core pillar, which provides direction and guidance to the Initiative (see Figure 10.2).



FIGURE 10.2 RNAO's Tobacco Intervention Initiative's multipronged approach.
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To highlight RNAO's approach to the spread and scaling up of this Initiative, the following pillars will be discussed in detail as they relate to the elements of scaling up and out described previously in this chapter:

- **Implementation sites** (adapting to local context and capacity building)
- **Schools of nursing and nursing students** (capacity building, engagement of implementers and partnerships)
- **TI Best Practice Champions and the TI Champions Network** (capacity building and engagement of implementers)
- **Social media and resources** (access to evidence-based resources)
- **Evaluation** (systematic methodology)
- **Partnerships and collaborations** (partnerships)

IMPLEMENTATION SITES

Since its inception with three public health units as implementation sites in 2008, over 45 healthcare organizations have partnered with RNAO to implement the BPG on smoking/tobacco cessation. This approach has provided opportunities for these organizations (public health units, primary care settings, community settings, hospitals, and academic institutions) to develop capacity in guideline implementation and tobacco cessation interventions. Capacity development is achieved through the support of an RNAO Tobacco Intervention Specialist and an onsite Champions workshop. Support from a TI Specialist is provided to staff at the implementation site based on the results of an organizational needs assessment and may involve consultation on planning, implementation, and evaluation and/or sustainability of practice change. Results of these activities include: smoking cessation identified as a priority program, specific smoking cessation interventions adapted for the community level, and organizational policy change. The *Toolkit: Implementation of Best Practice Guidelines* (RNAO, 2012b),

as described in Chapter 4, provides the framework for these consultations. The Champions Workshop focuses on evidence-based tobacco use interventions and how to access numerous evidence-based resources.

SCHOOLS OF NURSING AND NURSING STUDENTS

Recognizing the importance of basic education for nurses to enhance TI knowledge and skill within the nursing profession, RNAO looked to spread this concept to schools of nursing by influencing the undergraduate nursing education curriculum. RNAO's *Nursing Faculty Education Guide (NFEG): Tobacco Use and Associated Health Risks* (RNAO, 2010b) was created to develop the nursing faculty's capacity to integrate tobacco intervention best practices into nursing curriculum. Using principles of effective spread, the guide was based on the advice of an advisory committee of faculty and other stakeholders, best evidence in curriculum design, and the RNAO TI Best Practice Guideline.

To enhance uptake and sustained use as part of the scaling process, the *Education Guide*, consisting of practical tools and resources to facilitate uptake, was distributed to 157 schools of nursing across the country, targeting deans, directors, and nursing faculty leaders. It is available (in English and French) for free download on the TobaccoFreeRNAO website (<http://tobaccofreernaocan/en/NFEG>).

As part of the spread strategy, faculty representatives act as Champions/leaders/facilitators in integrating the NFEG resource at their academic institution. They seek, create, and coordinate opportunities to promote integration of tobacco cessation into the curriculum; develop and mentor others to support knowledge transfer (KT) of the *Education Guide* within the curriculum; network and raise awareness about TI resources, including RNAO's BPG; and serve as a resource to the faculty for KT related to TI and as a link to RNAO. RNAO also hosted nursing faculty working group meetings focused on the clinical aspects of TI, the *Education Guide*, and other resources, and from this, with widespread interest amongst nursing faculty across the country, an online community forum for networking is now active.

TI BEST PRACTICE CHAMPIONS

Since 2008, the TI Initiative has provided a total of 80 TI Champion workshops across Canada to over 5,500 nurses, other healthcare providers, and students to develop capacity in individual practitioners. Workshops are founded on the principles of adult education pedagogy and address knowledge, skills, and attitudes of participants in relation to their role in TI. Teaching methodologies include knowledge application sessions, role-playing, patient stories, and networking to foster integration of tobacco cessation interventions in daily practice in all health sectors.

Overall, the TI Champion workshops have been extremely successful in developing evidence-based knowledge and best practices essential for nurses and other healthcare professionals to effectively intervene with smokers. Each workshop educates TI Champions on how to implement the BPG into their practice settings, including education on brief intervention strategies, motivational interviewing techniques, and a focused and goal-directed client-centered counselling style. Participants have also gained knowledge of how to promote the use of TI best practices amongst their colleagues and how to engage with key stakeholders both within and beyond their organization. The TI Champions Network provides opportunities for ongoing sharing, collaboration, continuing education offerings, and networking to help nurses and other health professionals sustain integration of TI in daily practice.

SOCIAL MEDIA AND WEB-BASED RESOURCES

A comprehensive communication strategy and dissemination plan enhances the spread of activities and resources that support the TI Best Practice Champions in TI interventions and implementation activities. The social media and web-based presence of the TI Initiative is outstanding and consists of a number of elements outlined here:

- Regular social media messaging draws attention to online evidence-based resources and print materials.

- The TobaccoFreeRNAO website serves as a central hub for all TI communications, events, and tools, with people from over 191 countries accessing the site to date. All print and social media information is branded with the TobaccoFreeRNAO logo as shown in Figure 10.3.



FIGURE 10.3 TobaccoFreeRNAO logo.
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- TobaccoFreeRNAO has a steady presence on Twitter, with over 650 current followers.
- TI eLearning modules are popular and widely used resources amongst nurses, nursing students, and other healthcare providers. Over 3,225 individuals have completed the five TI eLearning modules to enhance their capacity in tobacco cessation interventions. These modules address helping clients quit, health professionals who smoke, mental illness and addiction and TI, TI for commercial tobacco use in indigenous populations, and TI in pre- and postnatal women.
- Knowledge exchange webinars on the integration of evidence-based tobacco cessation strategies into daily practice are interactive, archived following the session, and available through TobaccoFreeRNAO.ca.
- A virtual TI Community of Practice is hosted by RNAO on its online platform, a free professional networking website dedicated to communication and sharing of resources amongst those implementing best practices worldwide (<http://communities.rnao.ca/smoking-cessation/>). The “Resource Library” section includes a selection of tools shown to be effective in implementing evidence-based tobacco cessation interventions (<http://tobaccofreernaoc.ca/en/rnao-resources>).

EVALUATION

Evaluation is an important and consistent part of the TI Initiative and continues to be instrumental in highlighting the impact of the RNAO TI Best Practice Guideline in directing the evidence-based individual and organizational-level activities that are part of the TI Initiative. Through evaluation, we have learned the critical role nurses play as leaders in tobacco control and the impact of the TI Champions Network in supporting nurses to engage in TI best practices in their workplace settings. RNAO has partnered with the Ontario Tobacco Research Unit (OTRU) to plan and conduct the comprehensive evaluation which provides feedback enabling us to examine the impact of the Initiative and gain deeper insight into its successes, barriers, strategies, and critical learnings to sustain, spread, and scale up TI best practices in various settings across the country.

PARTNERSHIPS AND COLLABORATIONS

RNAO has formed strong partnerships with Smoke-Free Ontario–funded programs, other tobacco cessation projects, and initiatives related to chronic diseases and special populations. The aim of these partnerships is to ensure the successful integration, mobilization, and utilization of established services and programs for tobacco control in order to increase awareness and reach of the support and services available through the TI Initiative. These partnerships are mutually beneficial, as cross-promotion of each other’s resources allows for spread and enhances impact.

NATIONAL SPREAD: PAN-CANADIAN TOBACCO INTERVENTION INITIATIVE

The success of this project at the provincial level spurred Canada’s federal government to provide funding to RNAO over a 3-year period to replicate the TI Initiative and scale up to the national level in Canada, targeting all jurisdictions. Similar to the Ontario-based Initiative, the National Initiative focused on knowledge transfer, in particular related to the RNAO TI BPG, and mobilization of networks and increased use of existing services and programs to build capacity for tobacco interventions amongst nurses and other healthcare professionals.

The National Tobacco Intervention Initiative proved to be a huge success, with over nine provinces and territories involved, 40 workshops facilitated across Canada, and over 1,000 healthcare providers trained as TI Champions. The BPG was translated for use by a First Nations site that sparked further scaling up in northern First Nations communities. RNAO's current TI social media and web presence, discussed earlier in this chapter, helps these sites to sustain their work, and the Champion Network engages these Champions from the national sites.

SUMMARY

Key impacts of the TI Initiative include:

- TI and Tobacco Use Prevention Programs have a higher priority focus in Public and Community Health across Canada
- Policy changes in public health unit implementation sites reinforce TI and smoking-prevention programming
- Spread of Best Practice Guidelines into nursing education through integration of TI into undergraduate nursing curricula and the engagement of faculty and students as Champions
- Increased capacity of nurses and other clinicians in TI in a variety of populations across Canada, and adoption of brief TI intervention strategies into daily practice for nurses in all sectors
- Accessibility to evidence-based resources to support smoking cessation, TI, and prevention strategies for clinicians, students, and the public
- Networks for Champions and other professionals engaged in TI in their daily practice
- National acknowledgement of the TI Initiative for implementation across Canada

A number of aspects of scaling up, out, and deep have been demonstrated through this case study:

- The Initiative enables scaling up by extending the Tobacco Intervention BPG and related resources to all sectors in health and post-secondary education in nursing.
- The focused work with the Implementation Sites has resulted in scaling up and scaling out as organizational policy and planning incorporates TI, including prevention.
- The focus on capacity building for clinicians contributes to scaling up and scaling deep in relation to incorporating TI interventions into their daily practice.
- The engagement of Champions demonstrates use of a variety of delivery strategies (including diffusion and networking and train the trainer approaches) in the spread of best practices related to TI.
- The nature of the Champion program curriculum focuses on scaling deep and influences changes in attitudes of nurses and other clinicians about their role in TI, their competency, and effective ways to integrate these practices into their daily workflow.
- Engagement of stakeholders as partners in all aspects of the program has enabled sustained spread or scaling deep.
- The consistent inclusion of a comprehensive evaluation has enabled the TI Initiative to build on lessons learned, which has influenced scaling success.
- Scaling up was demonstrated in the nationwide spread, and the program components influenced both scaling out and scaling deep at the national level.

REFLECTION

What are the differences in approach to the integration of evidence-based content in the undergraduate nursing curriculum in Case Study 1 and Case Study 2? Which elements of these approaches do you predict will have the most long-term impact on scaling up?

C A S E S T U D Y

PREVENTION OF FALLS AND INJURY FROM FALLS IN THE OLDER ADULT

In 2002, RNAO published the first edition of a Best Practice Guideline, *Prevention of Falls and Fall Injuries in the Older Adult* (hereafter referred to as Falls BPG). At the time, falls were identified as a major focus for healthcare organizations, given that about 50% of residents in long-term care were falling each year; 7% of falls-related hip fractures were fatal; and falls contributed to pain, suffering, and a major economic burden on the healthcare system (RNAO, 2002).

In 2007, Safer Healthcare Now! (SHN!), a signature program of the Canadian Patient Safety Institute (CPSI), identified falls as a critical patient safety issue and fall prevention as a national patient safety priority (MacLaurin & McConnell, 2011). SHN!'s mandate is to reduce preventable adverse events across healthcare settings in Canada through the implementation of evidence-based interventions. Given RNAO's leadership on the topic of fall prevention, its evidence-based Falls BPG, and its expertise in knowledge translation and implementation science, CPSI approached RNAO to be the Intervention Lead for SHN!'s national Falls Prevention Intervention (MacLaurin & McConnell, 2011).

In 2008, a formal partnership between SHN! (CPSI) and RNAO was launched, and the two organizations embarked on a collaboration that would impact patient safety and healthcare practices for the next decade. This work involved a systematic approach to implementing practice change through quality-improvement science, access to evidence-based resources, capacity development at the individual and organizational level, and collaboration with national partners.

NATIONAL COLLABORATIVE ON FALLS PREVENTION IN LONG-TERM CARE (2008–2009)

The National Collaborative on Falls Prevention in Long-Term Care (hereafter referred to as the LTC Collaborative) was the inaugural initiative undertaken by the SHN!/RNAO partnership. The LTC Collaborative was conducted

from May 2008 to May 2009 and involved teams of five to seven interdisciplinary staff members representing 32 long-term care homes from across Canada.

The overarching goal of the LTC Collaborative was to reduce falls and injury from falls in LTC homes across Canada by 40% over a 1-year period, and the objectives were to provide:

- A dynamic, interactive learning experience that incorporates quality improvement and falls prevention theory, techniques, and tools to assist improvement teams in reaching their falls and injury prevention goals
- A forum for improvement teams to learn from faculty and exchange various approaches to quality improvement that they can test at the local level
- An opportunity for LTC improvement teams to participate in, and learn about, a Breakthrough Series Collaborative methodology that they can then utilize for other quality-improvement initiatives

SYSTEMATIC IMPLEMENTATION METHODOLOGY

The curriculum of the LTC Collaborative was informed by the second edition of the RNAO BPG *Prevention of Falls and Fall Injuries in the Older Adult* (2005b) and by theoretical models for change based in the quality-improvement literature. A conceptual model, the Falls Intervention Model, was developed to visually represent key evidence-based concepts from the RNAO guideline (see Figure 10.4). A *Change Package* was developed to operationalize best practices for the LTC Collaborative and guide the work of the teams (RNAO & SHN!, 2008). It highlighted four key change concepts: 1) design systems to avoid mistakes; 2) improve workflow; 3) manage variation; and 4) change the environment.

The Breakthrough Series Collaborative methodology (see Figure 10.4), a well-established approach within the quality-improvement world (Institute for Healthcare

Improvement [IHI], 2003), was used to structure each learning session.

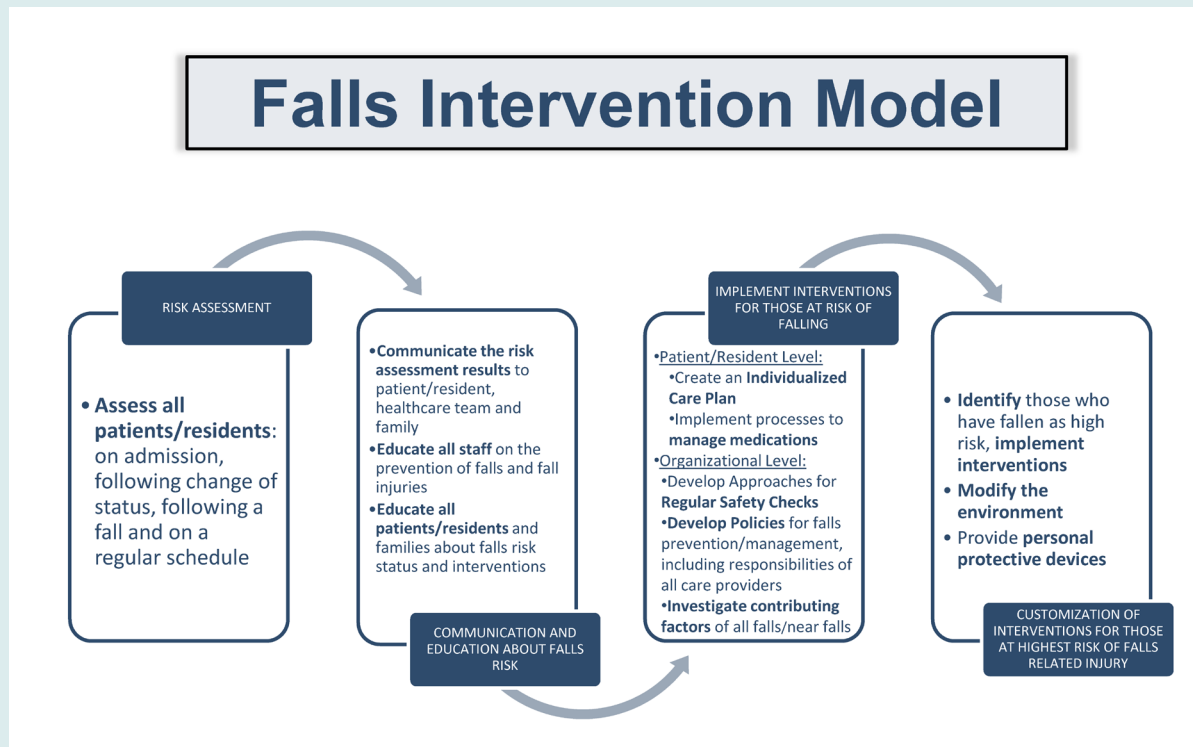


FIGURE 10.4 Falls Intervention Model.

Reprinted from *Journal of Safety Research*, 42(6), MacLaurin, A., & McConnell, H., Utilizing quality improvement methods to prevent falls and injury from falls: Enhancing resident safety in long-term care, p. 11.

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ELEMENTS OF THE LTC COLLABORATIVE

The LTC Collaborative included an interprofessional expert faculty and LTC teams recruited from across Canada to participate in the LTC Collaborative, which involved three in-person learning sessions and a closing session in sites spanning the country. Consistent with the collaborative model, between each learning session was an “Action Period” where teams conducted small tests of change using Plan-Do-Study-Act (PDSA) cycles based on the Model for Improvement (Langley et al., 2009), received extensive support and feedback from quality-improvement advisors and members of the falls faculty, and were encouraged to network with other teams within the LTC Collaborative. Monthly teleconferences and an online Community of

Practice (COP) for sharing ideas and resources were utilized to engage teams and build capacity in falls prevention strategies.

In the spirit of quality improvement, teams collected data on key process indicators such as: percentage of residents with completed fall risk assessments, percentage of risk assessments following status change, percentage of at-risk residents with intervention plans, and outcome indicators such as falls per 1,000 resident days and percentage of harmful falls. In addition, data were collected on a balancing measure, percent of restraint use, to ensure that falls interventions were not contributing to problems in other areas. The multiple structures and processes of the LTC National Collaborative are illustrated in Figure 10.5.

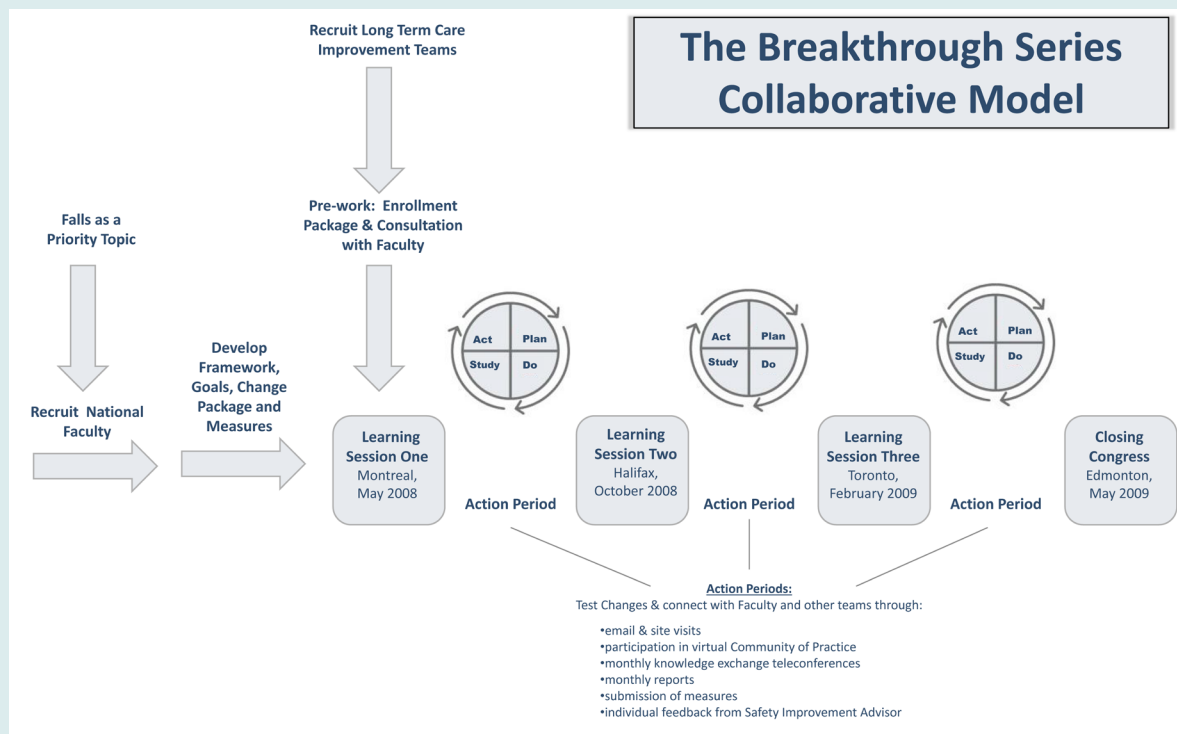


FIGURE 10.5 The Breakthrough Series Collaborative Model used for the National Collaborative on Falls Prevention in Long-Term Care (2008–2009). Reprinted with permission from the Canadian Patient Safety Institute.

OUTCOMES OF THE LTC COLLABORATIVE

Overall, the LTC Collaborative proved to be highly successful. Teams were fully engaged and found the process of learning from each other and sharing successes an effective way to support practice change within their long-term care homes. According to the evaluation results, the greatest improvements were noted in all three process measures, indicating that practice changes were being integrated with work processes in the participating homes. Furthermore, there was a notable decline in restraint use in those homes that submitted these data. Outcome measures were promising, with 16% of the LTC homes achieving or exceeding the goal of 40% reduction in a 1-year period. For other homes, the trends were positive; however, it was determined that more time would be required to scale out and deep, to embed and sustain practice changes before these outcome measures would be achieved. Further support of LTC homes was offered through a subsequent initiative led by RNAO through its partnership with SHN!—the Virtual Learning Collaborative.

VIRTUAL LEARNING COLLABORATIVE (2010–2011)

The National Virtual Learning Collaborative (Virtual Collaborative) built on the experience of the LTC Collaborative but using exclusively web-based technology to deliver a flexible and practical approach to learning, sharing, and networking. The initiative took place over an 8-month period and included many of the same elements of the LTC Collaborative. Virtual technologies were used to actively engage participants during and between meetings (e.g., webinars for learning sessions, including in-session chatting, question and answer sessions, virtual break-out rooms, and an online Community of Practice).

To guide the work of the quality-improvement teams, RNAO collaborated with SHN! on the development of another evidence-based resource entitled *Reducing Falls and Injury from Falls—Getting Started Kit* (hereafter the Falls GSK), which addressed interdisciplinary falls prevention initiatives in home care, acute care, and long-term care (SHN! & RNAO, 2010). This user-friendly resource was based on the recommendations from RNAO's

guideline *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2005b), quality-improvement methodology, and contributions from expert faculty.

Figure 10.6 provides an overview of the structure of the Virtual Collaborative, using the same Breakthrough Series Collaborative methodology applied in the LTC Collaborative.

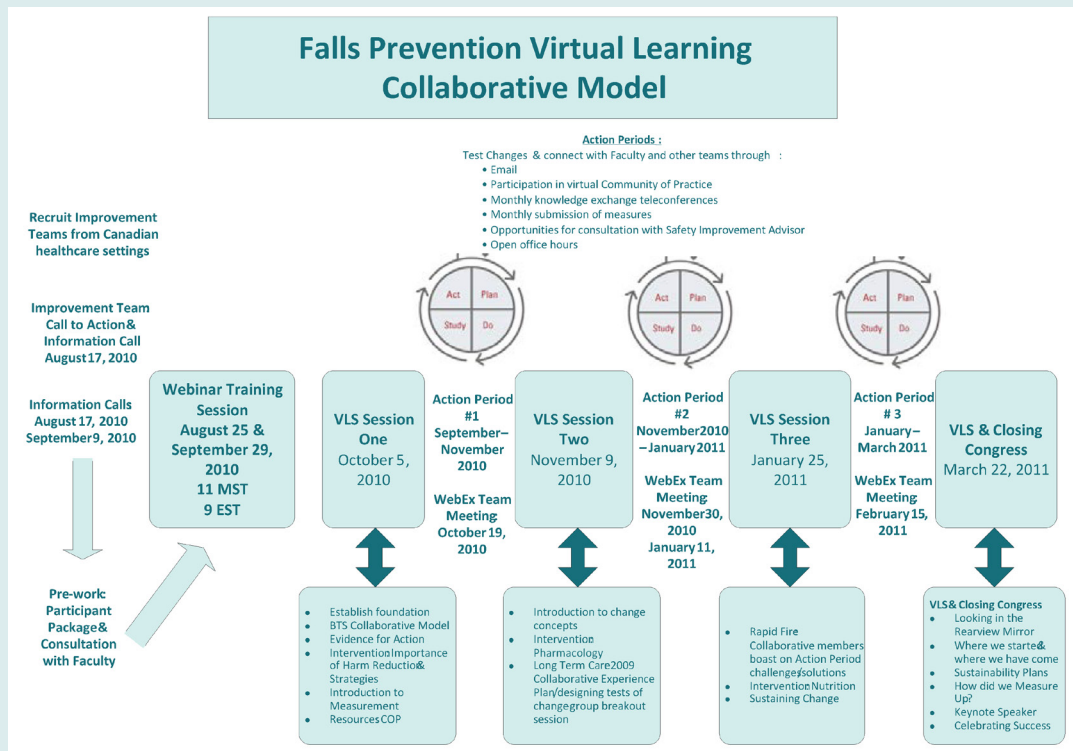


FIGURE 10.6 Falls Prevention Virtual Learning Collaborative Model.

Reprinted from *Journal of Safety Research*, 42(6), MacLaurin, A., & McConnell, H., Utilizing quality improvement methods to prevent falls and injury from falls: Enhancing resident safety in long-term care, p. 11. Copyright 2011, with permission from Elsevier.

OUTCOMES OF THE VIRTUAL COLLABORATIVE

The response to the Virtual Collaborative exceeded expectations. Over 47 organizations, representing 74 improvement teams, participated from a variety of sectors, including LTC, home care, acute care, rehabilitation, and mental health, with most Canadian provinces and territories represented. The findings were similar to those of the initial LTC Collaborative, in relation to practice change based on best evidence; however, in this instance, 26.8% of the participating teams reached the target of 40% improvement in reduction in falls causing injury (MacLaurin & McConnell, 2011).

The Virtual Collaborative initiative demonstrated that technology was an effective tool in scaling up and out,

resulting in major practice change in falls prevention in all sectors, and it enabled greater access to expert resources and peers. With the view that greater emphasis on sustained practice change would show greater impact on resident and patient outcomes, the partners collaborated on a third initiative focused on sustainability: the Falls Facilitated Learning Series.

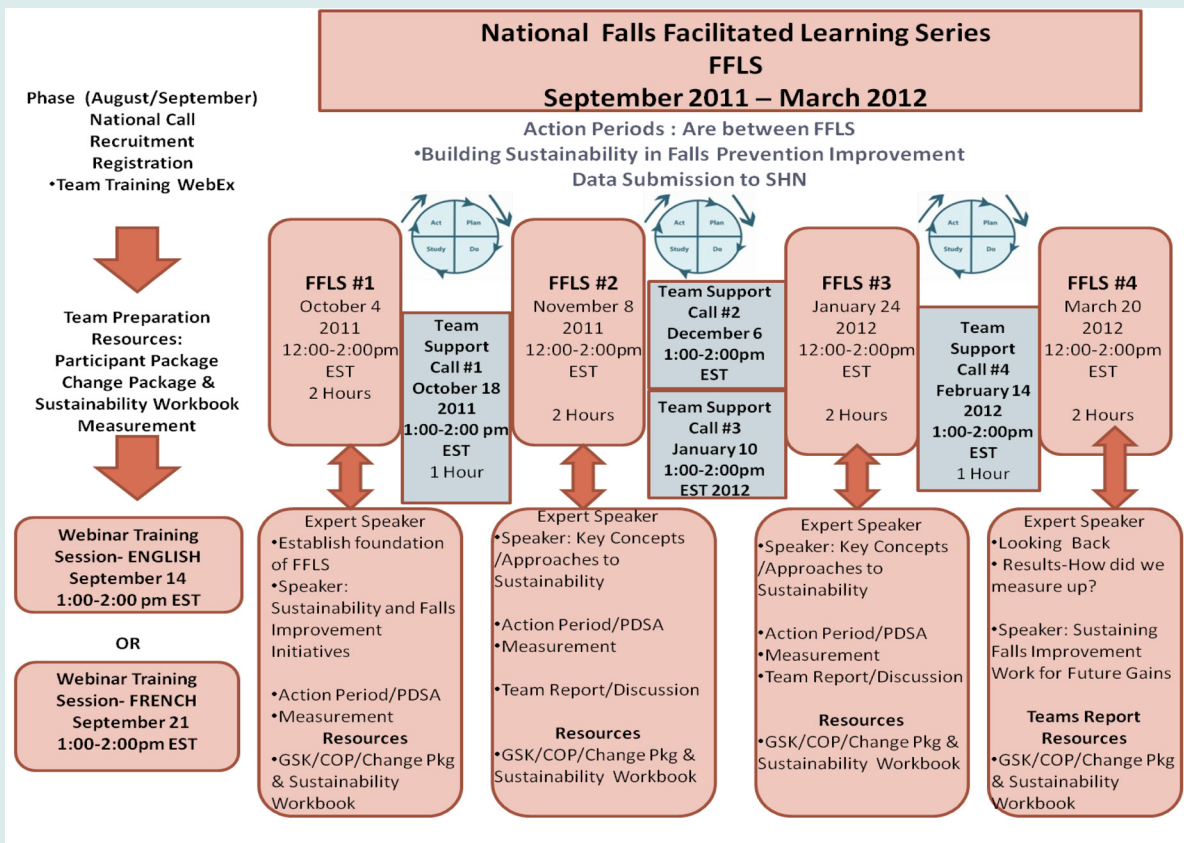
FALLS FACILITATED LEARNING SERIES (2011–2012)

The Falls Facilitated Learning Series (Learning Series) focused on sustainability of falls prevention interventions within practice settings. The purpose of the Learning Series was to help teams within healthcare organizations evaluate their existing falls prevention programs for

sustainability and to strengthen the uptake, spread, and integration of evidence-based best practices throughout the organization. Participating teams submitted baseline and follow-up data on the key process and outcome indicators used in other initiatives, with the goal of demonstrating a 20% improvement in these measures and sustaining the gains for 3 consecutive months. The Learning Series was rooted in evidence from RNAO's Falls BPG and quality-improvement theory, and resources developed for the previous initiatives, including the

Change Package and the *Getting Started Kit*, were utilized in conjunction with a new resource developed by RNAO, the *Sustainability Workbook* (SHN! & RNAO, 2011).

The *Sustainability Workbook* was grounded in implementation science, sustainability theory, change theory, and quality-improvement methodology. It provided teams with structured activities before learning sessions and focused questions during "action periods" to help them apply evidence within their practice. Figure 10.7 provides an overview of the structure of the Learning Series.



www.saferhealthcarenow.ca

FIGURE 10.7 National Falls Facilitated Learning Series.
Reprinted with permission from the Canadian Patient Safety Institute.

OUTCOMES OF THE LEARNING SERIES

Engagement in this initiative again exceeded SHN! and RNAO's expectations, with 41 teams participating in the Learning Series, representing provinces and territories across Canada and including acute care, home care, LTC, and mental-health settings. According to data submitted by participating teams, gains were noted across all three healthcare sectors, with improvements in the percentage of patients with completed assessments or screening on admission, and percentage of patients with a documented plan in place to reduce falls risk. Furthermore, 25% of home care, 55% of long-term care, and 69% of acute care settings also noted reductions in falls causing injury.

MAINTAINING MOMENTUM AND EXPANDING REACH

Following these successful spread, scale-up, and scale-out initiatives—which advanced from in-person to entirely virtual, and from a focus on LTC to the inclusion of all sectors, and resulting in the development of three evidence-based resources informed by the RNAO Falls BPG—RNAO has continued its partnership with CPSI as the national Falls Prevention Intervention Lead. The role of the Intervention Lead involves building capacity and supporting the uptake of falls-prevention best practices through sharing knowledge and expertise in falls prevention and implementation science, creating and updating evidence-based resources, and expanding the network of organizations engaged with fall prevention work. Table 10.2 provides a summary of these activities to date.

TABLE 10.2 FALLS PREVENTION INTERVENTION LEAD ACTIVITIES (2013–PRESENT)

ACTIVITY	DESCRIPTION
2013 2nd edition Falls GSK published	The Falls GSK was revised in collaboration with an interprofessional Pan-Canadian expert faculty. The GSK was published in English and French and disseminated through a national webinar and extensive national networks through RNAO and CPSI.
2013–2016 National Calls	One-hour knowledge exchange webinars facilitated by members of the Falls Faculty offered two to three times throughout the year. A range of topics engage a national audience and include using “positive deviance” and “frontline ownership” to support innovation in falls prevention, lessons learned from videos capturing fall events, and emerging research on appropriate footwear to wear in winter conditions.
2013–2014 Development of a falls audit tool	Over 14 months, RNAO collaborated with CPSI and Alberta Health Services to develop, pilot test, and implement the falls audit tool, informed by best practices outlined in the Falls GSK. The purpose of the tool was to support organizations to assess the quality of their falls-prevention and injury-reduction practices and determine areas requiring quality improvement.
2015 National Audit Month	A series of virtual orientation sessions were held for quality-improvement teams across Canada in home care, acute care, and long-term care to explain the falls audit tool and prepare for National Audit Month in April 2015. The audit event included 162 participating sites representing 3,499 records. Aggregated results provide a snapshot of the falls-prevention processes across Canada and were disseminated through a national webinar to participating teams. Organizations are using lessons learned from audit data to maximize strengths and address areas for quality improvement, and they are encouraged to continue to audit falls.
2015–2016 Home Care Safety Falls Prevention Virtual Improvement Collaborative	RNAO contributed expertise related to falls-prevention best practices to a Virtual Improvement Collaborative developed for the home care sector. This initiative was co-led by CPSI, the Canadian Home Care Association, and the Canadian Foundation for Healthcare Improvement and involved teams from five home care organizations from across the country.

continues

TABLE 10.2 FALLS PREVENTION INTERVENTION LEAD ACTIVITIES (2013–PRESENT) CONTINUED

ACTIVITY	DESCRIPTION
2015– Present Fall Prevention Month	RNAO and CPSI have collaborated with over 10 diverse organizational partners across Canada to develop, disseminate, and evaluate an online toolkit and other resources to support Pan-Canadian activities in recognition of Fall Prevention Month, held annually in November.
2017 RNAO Falls BPG, 3rd edition, published	The scope of this evidence-based Best Practice Guideline has been expanded to support fall prevention across the spectrum of care and amongst all adults (18 years and older) who are at risk of falls.
2017 <i>Falls Getting Started Kit</i> , 3rd edition	This edition of the Falls GSK reflects the same evidence summaries that informed the 3rd edition of RNAO's Falls BPG. The revisions have been focused on updating the evidence, and this work has been completed in collaboration with an interprofessional national faculty of falls experts.

Key impacts of the Falls Prevention Initiative include:

- Extensive spread of the Falls BPG through use of a quality-improvement approach and extension to a virtual methodology
- A successful partnership between RNAO and CPSI that used evaluation feedback and evolving technology to adapt and shape the Falls Prevention Initiative to advance spread and impact process and outcomes
- Sustained use of the Falls BPG across the country, with positive results, augmented by tools such as the RNAO Falls BPG, the collaborative curriculum, the *Change Package*, the *Getting Started Kit*, and the *Sustainability Workbook*
- Increased capacity of nurses and other clinicians in falls prevention, quality improvement, outcomes evaluation, and sustainability
- Accessibility to evidence-based resources, including expert faculty and peers, to support falls prevention activities
- Major changes in practice in all sectors across Canada with outcome improvements on falls and injury from falls

A number of aspects of scaling up, out, and deep have been demonstrated through this case study:

- Massive scaling up by extending the Falls Collaborative across the country and maximizing participation through technology

- Scaling out and deep facilitated by access to expert faculty, peer participants, and use of the quality-improvement and collaborative models
- Delivery strategies include networking, integrated approaches with quality-improvement initiatives, and local adaptation to various sectors
- The focused virtual work with the implementation sites has resulted in scaling up and scaling out as organizational policy and planning incorporates falls prevention
- The capacity building focus for clinicians in various sectors through the in-person and virtual sessions, and the key evidence-based resources, contribute to scaling up and scaling deep in relation to integrating falls-prevention strategies into daily practice
- The attention to evaluation as part of quality improvement has enabled participating sites to build on lessons learned, influencing scaling deep

REFLECTION

Thinking about all three case studies, what is the contribution of committed partnerships to advancing evidence-based practices in efforts to scale up?

CONCLUSION

The three case studies in this chapter show the phenomenal success RNAO is achieving—first in designing and delivering context-specific BPG-implementation interventions to meet the qualities of effective scaling, and second in addressing the full typology of scaling—scaling up, out, and deep.

In the first case study, the use of a conceptual model incorporating all aspects of Yamey’s (2011) framework sets the stage for impressive scaling in the health and education sectors at practice, policy, and cultural levels. The framework guides the systematic implementation methodology, used in the MH&A Initiative. Here we see how the elements of the framework, including access to evidence-based resources, capacity development opportunities, the engagement of Champions, and collaborative partnerships result in scaling up, out, and deep of RNAO’s evidence-based guidelines. These guidelines focused on mental health and addiction impact health-service delivery, organizational policy, secondary and post-secondary education, and the social service system. The case study demonstrates scaling deep through discussion of impacts on values and culture in the school system, in particular related to stigma and mental health amongst youth.

The second case study demonstrates the use of a multipronged strategy that informs a systematic implementation methodology and leverages mutually beneficial partnerships. This facilitates scaling of the smoking and tobacco-cessation BPG recommendations up, out, and deep to impact local and national target groups. The evidence-based resources, capacity development opportunities (both self-directed and facilitator supported), and the engagement of Champions in a range of roles and sectors aid in the scaling and spread activities in TI. Here we gain an appreciation for how scaling deep is fostered in the Champion curriculum and the supports provided to implementation sites and to the Champions Network. Scaling up and out are particularly evident in the deliberate integration of tobacco-cessation interventions within nursing program curricula and the impacts on organizational TI-related policies in all sectors.

The third case study shows how RNAO’s 15-year commitment to support healthcare providers, teams, and organizations in implementing best practices to prevent falls and fall injuries has spread country-wide, engaging organizations across the spectrum of care. It is an outstanding exemplar of successful scaling up, out, and deep. The partnership between RNAO and CPSI—together with expert falls faculty and in some cases other organizational stakeholders—shaped dynamic initiatives that engage quality-improvement teams and provide opportunities for capacity building. Best evidence, use of implementation science and quality-improvement methodologies, and committed partnerships were keys to the spread and scaling up of the fall prevention initiatives. With the attention to sustainment, and ongoing audit and feedback in particular, there is also strong evidence of scaling deep.

These diverse cases demonstrate the typology of scaling in three areas of health and healthcare that provide challenges for practitioners, policymakers, administrators, educators, and the public alike—mental health and addiction, smoking and tobacco cessation, and falls prevention. As illustrated in these exemplars, RNAO has leveraged its evidence-based BPGs and other resources, as well as a systematic implementation methodology and context-specific delivery approaches, to realize effective scaling.

Effective scaling up has meant extensive exposure in healthcare and beyond; effective scaling out has impacted policy and organizational priorities; and effective scaling deep has helped create cultures that sustain and spread evidence-based practices in each area. Through its BPG Program, for almost two

decades RNAO has been committed to closing the theory–practice gap in a way that will create lasting change with ripple effects for providers, clients, organizations, and the system. These cases demonstrate how well this is being realized.

KEY MESSAGES

- Successful scaling up, out, and deep of implementation initiatives requires attention to the evidence, the process, and individual/organizational capacity development.
- Champions at all levels are key to implementation of practice change and scaling up of proven approaches.
- Systematic implementation methodologies provide guidance and direction to project teams working to scale implementation up, out, and deep.
- Committed partners, with mutual goals for improving practice, can support the uptake and scaling of evidence-based practices in service and academic organizations.

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