Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	Number of Medically Complex hospital patients with a new pressure ulcer injury stage 2-4 in Complex Continuing Care. (Number; Complex continuing care patients; Average per Quarter January to December 2017; In house data collection)	666	4.00	2.00	1.00	Successful initiative resulted in a 75% improvement.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Measure, communicate and post completion rate for admission skin care risk assessment (Braden scale) and head-to-toe skin care assessment completed within 24 hours of admission.	Yes	Monthly updates were sent to staff updating them on the assessment completion rates. The update also included reminders to complete both the skin care risk assessment UDA and head-to-toe skin care assessment as there were times both were not completed. The communication was well received by staff.
Update and implement wound care process to standardize care based on risk status.	Yes	The process was updated and provided for staff use. Feedback must be obtained from staff to ensure the updated process is helpful. At this time the process is not fully being utilized, Management will continue to monitor and evaluate use.
Educate full time and part time active hospital nursing Staff on:	Yes	Education modules were implemented for all active nursing staff. Education was provided in person and through the Learning Management

Monitoring skin under medical or surgical device and Nutrition		System. Providing the education in two formats was effective; no challenges have been identified with Medical or Surgical device use at this time.
Educate full time and part time active hospital nursing Staff on: Repositioning and incontinence management & proper use of barrier creams	Yes	Education sessions were provided for staff. Additional sessions and resources are intended for existing and new staff in response to our staff's request for future education. This education will also be added to the annual skills fair attended by all staff. Ongoing information on positioning specific to each patient will be posted in the patient's room.
Develop and implement a standard wound care patient order set and wound care formulary, aligning wound cart and supplies with the order set.	Yes	Continuing to review and refine our wound care formulary. Due to costing some items will remain special order and will not be stocked routinely. A Nursing wound care Treatment Plan was created to allow nursing staff to independently manage wounds within their scope of practice and according to our wound care process.
Implement Health Quality Ontario (HQO), Patient and Resident Reference Guide for Pressure Injuries (2017) as part of patient education resources routinely in use in Complex Continuing Care.	Yes	The Guide is available and as appropriate provided to the patient.

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2	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	666	1.00	5.00	8.00	Successful first year of the project. Initiatives resulted in a 60% increase in reporting.

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Number of Full Time Equivalent employees in Hospital	Yes	198.6 FTE
Conduct a risk assessment to inform a multi-year plan by March 31, 2018.	Yes	Risk assessment standards are not available to refer to Assessment was completed and was in depth for all departments at SJHCG Risk assessment identified the organization’s gaps
Enhance and implement policy on workplace violence with input from frontline staff and where possible, clients and families by June 30, 2018.	Yes	Policy was developed after input from multiple individuals and teams Time intensive in development, especially around definition of workplace violence (i.e inclusion and exclusion criteria) Policy developed but also had to be coordinated and cross referenced with existing policies and process for workplace violence follow up and investigation
Educate active Hospital nursing, therapy and clerical staff on violence in the workplace and how to report by June 30, 2018.	Yes	Deadline extended due to need for completion of policy development/process (scope and time requirements extended beyond what was anticipated) Education development needed to include the policies and process which was time consuming Labour intensive in notifying and reminding managers and employees of deadline for completion Education impacted reporting as number of incidents reported increased after education
Create a reporting system to report and track incidents of workplace	Yes	Current system is paper based and need identified to implement an electronic system Current process involves paper copies being reviewed and data tracked manually for reporting

violence by June 30, 2018.		

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3	Number of workplace violence incidents reported by Long Term Care workers (as defined by OHSA) within a 12 month period. (Count; Worker; January to December 2017; Local data collection)	51950	41.00	51.00	61.00	Successful first year of the project. Initiatives resulted in a 48% increase in reporting.

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Enhance and implement policy on workplace violence with input from frontline staff and where possible, clients and families by June 30 2018.	Yes	Policy was developed after input from multiple individuals and teams Time intensive in development, especially around definition of workplace violence (i.e inclusion and exclusion criteria) Policy developed but also had to be coordinated and cross referenced with existing policies and process for workplace violence follow up and investigation
Educate active Long Term Care nursing, therapy and clerical staff on violence in the workplace and how to report by June 30 2018.	Yes	Deadline extended due to need for completion of policy development/process (scope and time requirements extended beyond what was anticipated) Education development needed to include the policies and process which was time consuming Labour intensive in notifying and reminding managers and employees of deadline for completion Education impacted reporting as number of incidents reported increased after education
Create a reporting system to report and track incidents of workplace violence by June 30, 2018.	Yes	Current system is paper based and need identified to implement an electronic system Current process involves paper copies being reviewed and data tracked manually for reporting

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4	Percent of long term care resident care plans updated with the appropriate resident profile and lift and transfer requirements (%; LTC home residents; New process to be implemented; Local data collection)	51950	0.00	80.00	100.00	Successful initiative was completely implemented 4 months ahead of target.

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Educate and train active full time and part time staff on the use of lifts, slings and transfer devices.	Yes	All LTC staff have been trained on the use of slings and lifts and transfers through the LMS and 1:1 training. In person training is also provided at orientation. This was a difficult change initiative, at first, staff did not accept the change with the transfer of new slings causing an increase to workload. Ongoing communication and support to staff has been provided to assist staff through this change. Identified that residents required adaptive clothing – this intervention has assisted with transferring concerns.
Review, recreate and apply long term care resident profiling and bedside logos.	Yes	All bedside logos have been created and are now in place in residents rooms Challenge to ensure that all information is accurate and that they are being updated in a timely manner.
Review, recreate and apply long term care resident bath schedule and routines.	No	The increased capacity in changing the lift and transfer equipment caused an increased need to change the bathing process. It was identified that further education was required on the use of bathing equipment and the use of “shower chairs” Change of towels was beneficial to residents as this increased their comfort and warmth during the bathing process
Review, recreate and implement formalized policies and processes	No	The policy and process was already in place once reviewed. It was identified that the equipment used was not being used as per manufacturer’s

related to mobility, lifts and transfers for long term care residents.		instructions and a culture shift needed to occur. Further to this, equipment was resurfacing and had to be removed from service in the moment.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
5	Percent of long term care residents whose mood from symptoms of depression worsened in the North Building: 2 North, 3 North and 4 North (2N, 3N & 4N) (%; LTC home residents; Average April to December 2017; In house data collection)	51950	16.70	14.20	15.40	This is the second year of the project. There were challenges with data collection and reporting. However the initiatives were successfully implemented and the unanticipated improvements for the residents and staff continue to be realized. Year three will be included on the QIP for 2019-2020.

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Educate all full time and part time active staff working on 2N, 3N and 4N on Section E of the Resident Assessment Instrument: Minimum Data Set (RAI-MDS).	Yes	This education was provided through LMS and through group huddles. With this education, staff were then documenting more accurate information and therefore impacted the data that is used for RAI MDS. It was identified that more follow up was needed with staff to ensure ongoing understanding and opportunity for questions to be clarified, monthly huddles on each unit were conducted to provide this opportunity and to touch base with staff to see how things were going
Implement engagement tasks based on depression rating scale (DRS)(% or more) for recreation team or designate roles on 2N, 3N and 4N.	Yes	This was an easier change to initiate as recreation therapy is always providing recreational activities and began to work with residents to identify engagement tasks better suited to their likes and interests
Implement engagement tasks based on a resident's depression rating scale (DRS)	Yes	It was identified that last year staff were concerned about finding time to complete these engagement tasks. Once staff

score of (3 or more) for Personal Support Worker (PSW) roles on 2N, 3N and 4N.		understood that these tasks could be incorporated into everyday tasks (like shaving someone and having a conversation with them) and were not meant to be lengthy (5mins not 30mins) staff were more receptive. Monthly huddles had a big impact on reviewing engagement tasks with the PSWs and identifying what tasks were going well and what could be added. PSWs were engaged in the huddles and began offering their feedback on engagement tasks for certain residents who were on the QIP
Provide quarterly updates and communication to most responsible physician (MRP) for residents who have a DRS of 5 or greater on 2N, 3N and 4N.	Yes	This purpose of this initiative was to alert physicians of possible concerns regarding mood and depression for their residents so that if needed follow up could occur. This was meant to provide information and updates to the physician