2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

University of Ottawa Heart Institute 40 Ruskin Street

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	Hospital collected data / most recent 3 month period	961*	CB	75.00	Collecting Baseline	1)Improve inpatient access to additional allied health services.	Evaluate the use of new admission screening tools that were created for last years QIP.	Determine the number of referrals made to Psychologist, Dietician and Social Work from the new nursing admission tool.	75 % of all patients that required referrals to Psychologist, Dietician and Social Work were completed based on the nursing assessment algorithm.	
	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	961*	78	78.00	Provincial Patient Experience average is 57%, UOHI has set a target to maintain 78% with a stretch target to reach 80% over the next two years.	1)Ensure that all of the educational guides are in plain, easy and understandable language.	Send our top three patient guides to our UOHI Patient Partnership Committee to have patients and families review them for clarity and ease of understanding. Use the Flesch-Kinkaid Grade level readability statistics to ensure documentation is at a grade 5 level for reading.	Review all patient guides with a senior friendly and health literacy lens.	Review educational guides by January 2019.	
										2)Review of teaching and educational materials for possible implementation in our new Electronic Health Record.	Review the Patient Oriented Discharge Summarge (PODS) toolkit for possible implementation in EPIC.	Compare the PODS toolkit with our Get with the Guidelines Applied in Practice tools for Heart Failure and Acute Coronary Syndrome.	Review completed by March 2019.	
		Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	A	% / Discharged patients	Hospital collected data / most recent 3 month period	961*	CB	CB	Improve our data collection of the discharge summaries.	1)Improve discharge communication	Improve discharge communication	Outline discharge summary rates by physician and share with with physicians. Work with EPIC team to create an alert and audit tool to ensure discharge summaries are completed within 48 hours of patient discharge. Advertise myottawaheart in discharge classes and medication bags.	Change processes completed by January 2019.	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	961*	17.82	15.50	UOHI readmissions for select HBAM inpatient grouper conditions Q4 16-17 risk adjusted is 10.4% substantially lower that other hospitals. We have set a maintanence target as we feel many of the readmissions are not related to a cardiac condition.	1)Outline readmission rates by physician and share the data with the physicians.	Provide each physician with their de-identification code so they can compare their number of readmissions to their colleagues at the UOHI.	Share the quarterly readmission rates with each Division head who will share the de-identified results with physicians in their Divisions.	Begin providing data quarterly by July 2018.	
										2)Update the interactive voice response system to include a question about physician follow up.	Use the interactive voice response system as a cue to get the patients to book their follow up appointments with their physicians.	Add interactive voice response question to existing survey: Do you have a follow up appointment booked with your general practitionner?	Interactive voice response system updated with new question by June 2018.	
										3)Develop a feasibility study for the use of Cardiomems.	Review literature and develop criteria for a patient pilot using cardiomems in select heart failure patient population to prevent readmission. Look for funding sources for a cardiomem pilot.	Approval of Cardiomem pilot.	Complete feasibility study by March 2019.	
	Wound Care	Percentage of patients who develop a pressure injury after admission.	C	Rate / All inpatients	Local data collection / 18-19	961*	3	3.00	Maintain	1)Change the culture of pressure ulcer to pressure injuries.	Work with the nursing unit educators and managers to create a culture change in how pressure injuries are viewed.	Create pressure ulcer educational module to assist nurses in the staging of pressure injuries. Education and Culture change: pressure injuries are preventable in hospital, reportable in the UOHI Safety Learning System (SLS) Conduct a mini root cause analysis for each pressure injury reported in SLS to make system changes and prevent other injuries from occurring.	Culture change shift by March 2019.	
Equitable	**Indigenous Training**	Internal Staff Indigenous training	C	education module / Worker	internal / 17-18	961*	85	80.00	Annual training is available for all physicians and clinical management staff.	1)Improve the access to care and treatment for Indigenous populations.	Educate physicians and management team on treatment plans for Indigenous populations.	Completion of training module by all physicians and management staff.	80% of all physicians and management will have completed the traing by March 2019.	
	Patients with Substance Abuse Disorder	Access to appropriate care and treatment	C	staff education / Inpatients with substance abuse disorder	internal / 18-19	961*	CB	CB	Collecting Baseline	1)Improve the access to care and treatment for substance abuse disorder patients.	Educate Staff on the social and physiological issues associated with this select population.	Create Substance Abuse Disorder educational Module. Coordinate additional education sessions for staff.	Completion of educational module by January 2019.	
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	961*	91.9	92.00	Provincial Patient Experience top 10% Average is 89.8%. The UOHI has set a target to maintain 92%.	1)To further engage our patients and families in our quality improvement initiatives.	Develop a Partnering with Patient and Families Toolkit for Program Leaders to formalize and enhance the role of patients and families as advisors in hospital quality improvement activities.	Development of the Partnering with Patient and Families Toolkit.	The Toolkit will be develop by December 2018.	
										2)Learn from the experiences of patients and families at other hospitals.	Connect with the Ontario Patient Ombudsman and ask for a synopsis of the cases that have been reviewed in 2017.	Review complaints received by the Ontario Patient Ombudsman for any system changes that we should consider in our institution.	Complete the review by February 2019.	
										3)Connect with patients and family members to improve their expectations of their upcoming experience.	Survey patients and families to find out what they are interested in knowing more about prior to coming into the hospital.	Develop wayfinding videos to assist patients in navigating the new building and provide them with an expectation of their upcoming experience.	Videos completed and uploaded to our external website by June 2018.	
										4)Enhance the relationship between families and caregivers and the UOHI.	Update the patient experience cover letter and elective questions to capture the experiences of families and caregivers.	Modify NRC elective questions and cover letter to provide families and caregivers an opportunity to provide feedback.	Modify questions and cover letter by May 2018.	
		Percentage of complaints acknowledged to the individual who made a complaint within three to five business days.	A	% / All patients	Local data collection / Most recent 12 month period	961*	100	100.00	Our internal process includes acknowledgement of concerns within 2 business days.	1)Changes to the management of concerns.	Alignment of current practices for concerns management with provincial changes.	Create a new Concerns Management Template and incorporate the Concern categories and follow up actions to be in line with QIP reporting. Develop a survey to assess satisfaction with concern management.	Changes implements by August 2018.	
Safe	Safe care/Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	961*	92.12	92.12	% reflects Q2 17-18. Q3 is not yet available.	1)Focus on improving the quality of the information being gathered at the time of admission.	Pilot the mail out of questionnaires to each elective procedural patient to capture patient medications, pharmacy and family physician information. Audit bi-annually for quality of medication reconciliation at admission.	Pilot the mail out a questionnaire to each elective procedural patient to capture patient medications, pharmacy and family physician information. Audit bi-annually for quality of medication reconciliation at admission.	Completion of two prevalence audits to determine the accuracy of the admission medication information being captured by March 2019.	
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	961*	87.69	90.00	Sample taken in January 2018. Q3 is not currently available.	1)Development of the EPIC medication reconciliation module.	Working with the EPIC team and the Fusion Project partners to develop a medication reconciliation module (Willow).	Working with the EPIC team and the Fusion Project partners to develop a medication reconciliation module(Willow).	Complete the build of the new Willow application in EPIC by January 2019.	
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2017	961*	14	14.00	UOHI has set a maintanence target as we feel that many of our workplace violence incidences come from delirious patients with no mal intention. UOHI is working with staff to improve the identification of these patients so they feel more prepared.	1)Standarize Violence Flagging through the Institution.	Devise a plan to ensure that non-clinical staff can easily identify patients that have been previously flagged as violent.	Standardize and educate staff on the new process.	80% of staff trained on new flagging system by December 2018.	FTE=1000
										2)Improve policies and practices to ensure staff feel more safe in their workplace.	Pilot the removal of employees surnames on their badges. Revision of the Occupational Exposure/algorithym policy to ensure blood tests can be pursued where applicable.	Pilot the removal of employees surnames on their badges. Revision of the Occupational Exposure/algorithym policy to ensure blood tests can be pursued where applicable.	Complete pilot and policy revisions by March 2019.	
										3)Risk Assessment of the first floor.	Conduct an employee survey, to have them identify the potential risks. Occupational Health and Safety to meet with manager to conduct physical review of the areas.	Number of risks identified through the risk assessment.	Completion of the risk assessment by March 2019.	
										4)Increase the awareness of the non-violent crisis intervention training availble to staff.	Send regular communication to the managers about the training times and a reminder that the non-violent crisis intervention training is offered.	Make non-violent crisis intervention training available to staff.	Communication plan completed by March 2019.	
	Surgical Site Infections	Rate of surgical site infections for all major procedures.	C	% / All inpatients	CIHI DAD / 16-17	961*	3.99	3.99	We have set a maintain target for the coming year with a stretch target of improvement.	1)Review of the literature from Surgical Thoracic Society on the implications of pneumonia for surgical patients and the impact on surgical site infections.	Review surgical site infection patient population to determine if there were indications for pneumonia.	Complete full chart abstraction and review.	100% of fiscal year 17-18 charts reviewed by November 2018.	
Timely	Timely access to care/services	Elective CABG 90th Percent Wait Time within 90 Days of Referral	C	90th percentile / elective CABG	WTIS / 17-18	961*	64	80.00	Variable month to month	1)Streamline and improve the surgical triage process.	Conduct a Failure Mode Effect Analysis on the surgical triage process.	Conduct a Failure Mode Effect Analysis on the surgical triage process and implement changes over the coming year.	Completion of Failure Mode effect Analysis and streamline process by March 2019	