2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

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AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce 30 day readmission rates for select HIGs**	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	961*	14.18	14.18	Maintain target of 14.18% with a stretch target of 12% over the next few years.	1)Develop a trigger system to alert staff of all unplanned 30 day readmissions and an assessment tool to help identify root causes.	Collaborate with Health Records and Nursing Coordinators to develop a trigger system and assessment tool for patients readmitted within 30 days.	A trigger system and assessment tool will be developed by Oct 2016.	100% of all patients will be reviewed for readmission trigger system and all readmissions will	
									2)Pilot the use of a key learner to improve uptake of education and family support during the transition to home.	Senior Friendly committee will develop a strategy and communication guideline for identifying key learner.	# of admissions with key learner identified on admission.	90% of Heart Failure admissions will have key learner identified by July 2016.	
									3)Evaluate the use of the HF stoplight tool to increasing patients understanding of signs and symptoms of Heart Failure exacerbation.	Add additional questions to Day 7 and Day 30 IVR to assess patient understanding of heart failure exacerbation signs and symptoms.	# of patients responding to questions at day 7 and day 30 IVR call.	90% of patients in our HF IVR program will understand the signs and symptoms of HF exacerbation.	
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	961*	15.63	14.00	Stretch target of 12% over the next two years.	1)Review Heart Failure Education using a senior friendly lens.	The Senior Friendly committee will review and make recommendations for changes as required.	Review will be completed and changes will be made by Feb 2017.	100% of all Heart Failure patients will receive by March 2017.	
									2)Review the role of the Transitional Care Nurse for Heart Failure.	The Senior Friendly committee will review and make recommendations for changes to the role.	All changes will be implements by March 2017.	All changes will be implements by March 2017.	

Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	961*	0.7	0.70	Maintain 0.70 as we have decrease from 1.14 over the previous year.	1)Evaluate the success of the Home First Program.	Review the referrals from UOHI to nursing homes before and after Home First Program.	Compare the # of patients referred to nursing home after initiation of the Home First Program to the # of patients referred prior to the Home First Program.	Collecting baseline data.	
Equitable	**Other**	Add other measure by clicking on "Add New Measure"	Other / Other	Other / other	961*	CB	0.00	UOHI is not collecting this information	1)While we do not yet have an equity indicator, we are addressing equity by offering cultural competency training for staff and by ensuring our	While we do not yet have an equity indicator, we are addressing equity by offering cultural competency training for staff and by ensuring our patient experience surveys are available in multiple languages.	While we do not yet have an equity indicator, we are addressing equity by offering cultural competency training for staff and by ensuring our patient experience surveys are available in multiple languages.	While we do not yet have an equity indicator, we are addressing equity by offering cultural	While we do not yet have an equity indicator, we are addressing equity by offering cultural
Patient-centred	**Improve patient satisfaction**	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	961*	99.2	98.00	The QIP average benchmark for this indicator is 96.4%; although we will continue to strive for excellence we feel that setting a retrograde target or 1% can be maintained.	1)Staff will complete an education module to improve communication techniques with patients.	Develop Communication Module within our Patient Safety Education to assist staff in effectively communicating with patients.	# of patient concerns regarding interpersonal communications.	100% of employees will have completed the Patient Safety Education by Feb 26, 2017.	
									2)Develop a Patient Engagement Steering committee.	Develop Terms of Reference for Patient Engagement Steering committee and bi-annual meetings.	# of times the committee meets per year.	The steering committee will meet twice by March 31, 2017.	
									3)Improve whiteboard communication.	Clinical managers will engage patients on the use of our whiteboards during rounds.	# of whiteboards with up to date RN name, MD name, date and discharge plan.	95% of our patients will have up to date discharge plans on the whiteboards.	
									4)Share patient stories.	Share patient stories at Orientation. Add patient stories to Patient Safety Education Module.	100% of new hires will attend orientation sessions. Add patient stories to Patient Safety Education Module.	100% of new hires will attend orientation sessions. New module will contain a few	
									5)Transition to Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey (CPES).	Collect baseline data using this new surveying tool. Map old survey questions to new survey.	Collect baseline data using this new surveying tool.	New tool will launch in April 2016 and comparison of all questions will be completed by July	
		"Would you recommend this hospital (inpatient care) to your friends and family?" add the	% / All patients	NRC Picker / October 2014 – September 2015	961*	95.7	93.00	The QIP average benchmark for this indicator is 81.8%; although we will continue	1)Develop an educational module to improve communication techniques with patients.	Develop a Communication module within our Patient Safety Education to assist staff in effectively communicating with patients.	# of patient concerns regarding interpersonal communications.	100% of employees will have complete the Patient Safety Education by Feb 26, 2017.	

		number of respondents who responded “Yes, definitely” (for NRC Canada) or “Definitely yes” (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).						to strive for Excellence we feel that setting a retrograde target of 2% can be maintained.	2)Develop a Patient Engagement Steering committee.	Develop Terms of reference for Patient Engagement Steering committee and annual meetings.	# of times the committee meets per year	The steering committee will meet twice by March 31, 2017.	
									3)Improve whiteboard communication.	Clinical managers will engage patients on the use of our whiteboards during rounds.	# of whiteboards with up to date RN name, MD name, date and discharge plan.	95% of our patients will have up to date discharge plans on the whiteboards.	
									4)Share patient stories.	Share patient stories at Orientation. Add patient stories to Patient Safety Education Module.	100% of new hires will attend orientation sessions.	100% of the new orientations will have a patient representative in attendance to share	
									5)Transition to Canadian Institute of Health Information(CIHI) Canadian Patient Experiences Survey (CPES).	Collect baseline data using this new surveying tool. Map old survey questions to new survey.	Assess and compare baseline data to prior survey.	First year of baseline data will be completed.	
	Improve patient transitional care	Partner with 4 regional hospitals to improve transitional care.	% / All HF patients	Hospital collected data / Jan-Dec	961*	50	100.00	All four hospitals have committed to this transitional care partnership.	1)Pilot a two year partnership with 4 regional hospitals to improve transitional care through the use of post discharge phone calls.	Pilot a two year partnership with 4 regional hospitals to improve transitional care through the use of post discharge phone calls.	Use of Interactive Voice Response to call all day 7, 1 month, 3 months, 6 months and 12 months post Heart Failure Discharge patients.	Number of patients who receive the day 7, 1 month, 3 months, 6 months and 12 months call	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	% / All patients	Hospital collected data / most recent quarter available	961*	77	80.00	Medication Reconciliation continues to be a priority for Ottawa Heart. We have set the 80% target based on still having a manual process in place.	1)Revise UOHI corporate medication reconciliation policy.	Quality Department will develop a UOHI specific medication reconciliation policy.	Development of policy.	Policy will be communicated to all staff and physicians by Sept 2016.	
									2)Develop an education module for medication management for new physicians.	Quality Department will collaborate with chief residents to develop training module.	# of physicians that have completed the module.	100% of physicians will have completed the training module by March 2017.	
									3)Real time feedback.	Conduct daily audits at 24 hour mark of admission to provide feedback to physicians who have not yet completed the medication reconciliation on admission.	# of patients that do not have a best possible medication history completed with 48 hours of admission.	100% of admission will have best possible medication history completed within 24 hours of	

Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	961*	CB	80.00	As we are collecting our baseline for the coming year, we have set a stretch target of 80%.	1)Revise UOHI corporate medication reconciliation policy to include transition and discharge.	Quality Department will develop a UOHI specific medication reconciliation policy.	Development of policy.	Policy will be communicated to all staff and physicians by Sept 2016.	
								2)Improve documentation process.	Quality Dept will work with Health Records to help them understand the medication reconciliation process and develop guidelines for data collection.	# of patients with completed medication at discharge completed.	80% of our patients have medication reconciliation at discharge completed by October 2016.	
								3)Develop an education module for medication management for new physicians.	Quality Department will collaborate with chief residents to develop training module.	# of physicians that have completed the module.	100% of physicians completed the training module by March 2017.	
Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	961*	0.4	0.30	Median for ON hospital with 101-300 beds is 0.36%. Stretch target of 0.26%.	1)Improve environmental cleaning.	Improve SWAT process to further identify rooms that have C.Difficile patients and require a deeper cleaning.	# of times the clorox sticker is applied in room of C. Diff patients.	Clorox sticker is applied to rooms with C.Diff positive patients 100% of the time by December	
								2)Engage patients and families in Hand Hygiene.	Clinical Manager and Infection Control will collaborate to educate staff on how to engage patients and families in hand hygiene.	# of times hand hygiene is performed on pilot unit at the key indicators for patients hand hygiene; including, before meds, before meals and after bathroom.	100% compliance with appropriate hand hygiene moments patients.	
								3)Antibiotic Stewardship	Form a group to assess the appropriateness of antibiotics that may contribute to acquiring C.Difficile.	Recommendations related to antibiotic use will be developed.	100% of recommendations will be followed.	
								4)Review literature on the practice of hospitals providing probiotics to patients who are on antibiotics.	Set up meeting with infection control and review the current literature to develop a corporate position on prophylactic probiotic treatment.	Complete review of the literature. Develop and implement recommendations.	Recommendations will be communicated to the medical staff.	
	Number of times that hand hygiene was performed before initial patient contact during the reporting	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	961*	97.67	97.00	Our goal is to maintain 97% but we have set a stretch target of 100%	1)Engage patients and families in hand hygiene.	Clinical Managers and Infection Control will collaborate to educate staff on how to engage patients and families in hand hygiene.	# of times hand hygiene is performed on pilot unit at the key indicators for patients hand hygiene; including, before meds, before meals and after bathroom.	100% compliance with appropriate hand hygiene moments for patients.	

		period, divided by the number of observed hand hygiene opportunities before initial patient contact							2)Evaluate the knowledge of hand hygiene protocols specific to the Cardiac Operating Room.	Evaluate and provide inservices for staff on Hand Hygiene protocols in the COR.	# of staff that attend the inservice for hand hygiene protocols in the COR.	100% of staff will receive the COR hand hygiene education by July 2016.	
	Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100.	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	961*	98.34	100.00	Our target is to complete 100% of SSCL for non-emergent cases.	1)Implement new PICIS database to capture specific elements being missed in SSCL.	Provide feedback to physicians regarding missed opportunities.	# of times that each phase of the Surgical Checklist is completed.	100% of patients will have all 3 phases of the SSCL completed by December 2016.	
									2)Analyst will provide monthly feedback on SSCL compliance to Cardiac Operating Committee.	Extract and compile data for the team on a monthly basis.	Monthly reports are provided.	The team will review monthly report and analyze any failures.	
									3)Add elements of surgical site Infection prevention into checklist.	Assess pre-operative clipping, pre-operative infections; Review normothermia in debrief.	Checklist includes SSI prevention indicators.	New elements are added into checklist.	
Timely	**Reduce wait times**	Elective CABG 90th Percent Wait Time within 90 Days of Referral	% / All patients	Hospital collected data / Jan-Dec	961*	94	90.00	This measure continues to be an internal priority. We will continue to strive to achieve 90% within recommended wait time. Stretch target of 100%	1)Review urgent wait times monthly at Quality of Care Committee and Senior Management.	Develop monthly scorecard for urgent wait times.	# of elective patients completed within 90 days of referral.	90% of elective CABG referrals completed within 90 days of referral.	
									2)Implement new PICIS database to capture electronic real time data.	Track utilization metrics on COR usage.	# of times the COR experience lost time.	Collecting baseline by November 2016.	