مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة

All Committed to Improve 2018
Performance Improvement Project Charter

Strategic Priority: SP3- Organizational Sustainability

Project Name

Enhance Heart Care at home

Site	Department
Riyadh	Cardiovascular Nursing and Heart Center

Project Status	Project Start Date	Project End Date
Completed	05-27-2018	03-10-2018

Problem: Why the project was needed?

Organizational Sustainability is one of the KFSH&RC priorities; The Heart Center (HC) together with Cardiovascular Nursing contribution to this priority will be through optimizing efficiency, productivity, being accountable to optimize the bed utilization and delivery of care and optimizing patient quality of life. One of the challenges that we are facing, is the increase of re-admission for heart failure patients, because of their poor compliance. Sustaining our quality of care is another reason for this project.

Aims: What will the project achieve?

Decrease the percentage of Re-admission for Decompensated Heart Failure patients to less than 25% from the international benchmark by the end of October 2018 and sustain it for 6 months

Benefits/Impact: What is the improvement outcome?

(check all that apply)

- ☒ Contained or reduced costs
- ☒ Improved productivity
- ☐ Improved work process
- ☐ Improved cycle time
- ☒ Increased customer satisfaction
- ☐ Other (please explain)
  Click or tap here to enter text.

Quality Domain: Which of the domains of healthcare quality does this project support?

(Select only one)

Efficient

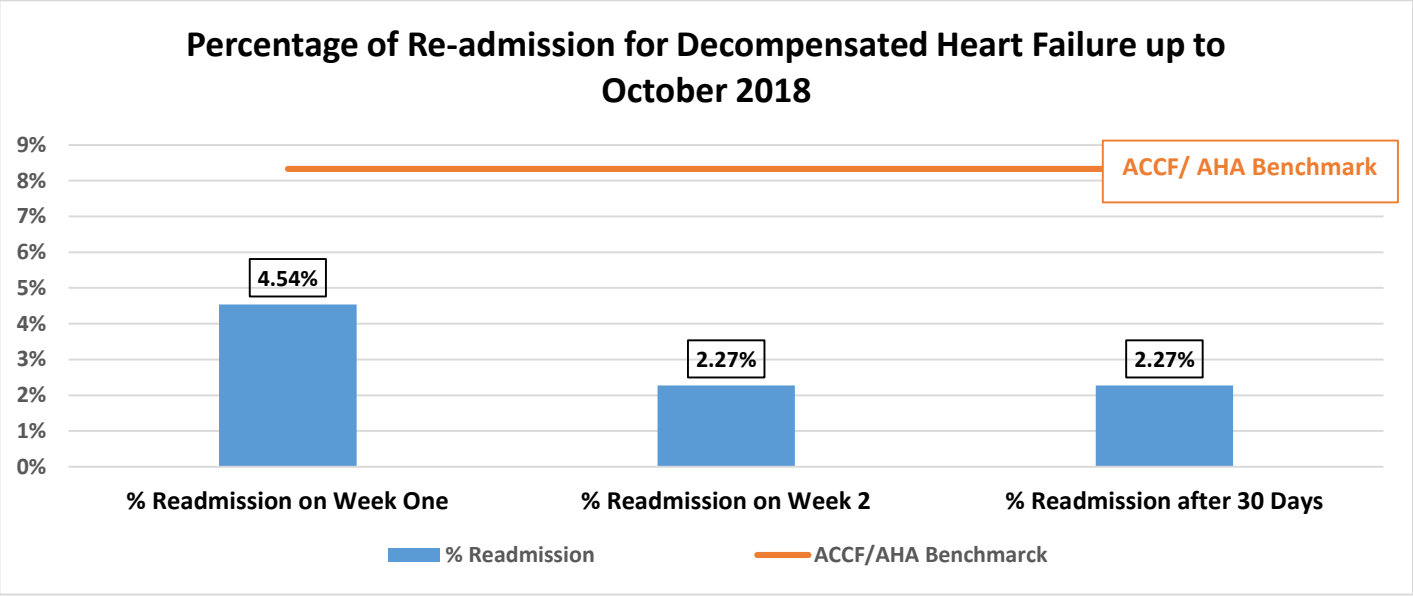
Measures: Performance metrics to be evaluated	**Targets:** Expected outcomes
Percentage of Re-admission	less than 25%

Interventions: Overview of key steps/work completed

- Commence of an intensive education program to all heart failure patients while they are in-hospital. This education program is in a form of presentation and handouts, it covers what is heart failure, sign/ symptom of HF, medications for HF and life style.
- Initiate an easy way of communication between HF/CNC and patient to adjust their medication or to find a solution to their concerns via what's app24/7.
- Formulate patient passport and provide it to the patient on the day of discharge, which has all of his discharge medication (timing and dose); there is a form whereby the patient will record his daily weight and BP; it has the contact number for HF team. This is a tool that the patient will carry with him / her whenever he needs to be seen by any medical specialty.
- Enroll in Home monitoring program for some patients whereby, we can monitor them while they are at home.
- Call patient after discharge on week one, on week 2 and 30 days after, to check on them and on their compliance to their medication and daily activities.
- Facilitate early appointment with HF/CNC to follow their condition.

- Guide patients to what kind of care they need based on their clinical condition without going through EMS.
- Provide an open access to see HF/ CNC during the week at any time.

Results: Insert relevant graphs and charts to illustrate improvement pre and post project
(insert relevant graphs, data, charts, etc.)



Project Lead	Team Members
Name *(person accountable for project)* Nada Abutalb	**Names** *(persons involved in project)* Marilla Akiki Abir Ibrahim