Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for St. Joseph's Health Care London

St JOSEPH's HEALTH CARE LONDON

3/31/2014

Overview

"Being a National Leader in Quality and Patient Safety" is a strategic goal for St. Joseph's Health Care London (St. Joseph's). In pursuit of this goal we are proud to have received the highest Accreditation Canada award of "Accreditation with Exemplary Standing". As well, St. Joseph's was identified as the high performer for patient satisfaction among all Ontario Teaching Hospitals for acute inpatient care. Despite these accomplishments, St. Joseph's continues to identify areas where we can improve the care and service we provide to patients, residents and families.

Annually, St. Joseph's develops and publicly posts its Quality Improvement Plan (QIP) which outlines the key quality improvement priorities for the upcoming year. Our 2014-2015 QIP priorities are outlined below.

Achieve a 10 per cent decrease in the number of falls resulting in injury at Mount Hope Centre for Long Term Care and Parkwood Hospital

Minimization of patient falls and in particular falls resulting in injury is a high priority for St. Joseph's. Approximately 85 per cent of our falls occur at Parkwood Hospital and Mount Hope Centre for Long Term Care, where many of our patients and residents are at an increased risk of falling. Reduction of falls resulting in injury was a key priority for 2013-2014 and we have been successful in meeting our goal of reducing falls resulting in injury by more than 20 per cent. We wish to continue to build on those improvements by achieving an additional 10 per cent reduction.

Improvement initiatives include hardwiring specific best practices across all units including intentional comfort rounding with patients (purposeful hourly rounding), post-fall reviews/debriefing, and falls risk assessments. An e-learning module on falls prevention is to be completed by 90 per cent of clinical staff in 2014-2015 and communication tools will continue to be utilized to heighten awareness of falls and successes with falls reduction.

Achieve 95 per cent hand hygiene compliance

Proper washing of hands before patient contact is a key component to protecting staff and patients from getting an infection. Based on currently available comparative data, a compliance of 95 per cent would place St. Joseph's among the high performers in Ontario. This goal builds on St. Joseph's hand hygiene target for 2013-2014 (90 per cent) and is the next step in our ongoing effort to continuously improve our performance in this area. Strategies to achieve this goal include enhanced auditing, reporting and follow-up on hand hygiene audit results, leveraging and sharing the strategies of high-performing areas, and continuously removing identified barriers of performing hand hygiene.

Achieve 10 per cent reduction in the use of seclusion and restraints in mental health care

Minimization of the use of seclusion and restraints in our two mental health sites (Regional Mental Health Care London and Southwest Centre for Forensic Mental Health Care) is a key priority. Strategies in 2013-2014 led to reaching our goal of a 25 per cent reduction in seclusion and restraint use, and our desire is to achieve an additional 10 per cent reduction in 2014-2015. Strategies include education, training and compliance with guidelines/protocols, development and utilization of strategies for alternatives to restraint/seclusion use, and environmental changes that minimize the need for seclusion and restraint use.

Achieve 95 per cent medication reconciliation at admission and reduce specific medication errors by 80 per cent.

Medication safety is a key focus for St. Joseph's and is aligned with Accreditation Canada's priorities for patient safety as well as the Ontario Ministry of Health and Long-Term Care priorities. In 2014-2015, St. Joseph's is implementing an initiative called HUGO (Healthcare Undergoing Optimization). HUGO involves the implementation of:

- Computerized Provider Order Entry
- Electronic Medication Administration Record
- Closed Loop Medication Administration
- Electronic Medication Reconciliation

The above components will result in safer ordering, verification, administration and reconciliation processes. This will significantly improve medication reconciliation and reduce incidents of specific types of medication errors (patients receiving the incorrect medication).

Achieve 5 per cent improvement of patient/resident ratings of "excellent" for overall quality of care in mental health care and at Mount Hope Centre for Long Term Care.

Patient experience and satisfaction is a focus in all programs at St. Joseph's and is aligned with our vision of "earning complete confidence" in the care we provide. In many areas patient satisfaction is similar to or above average in comparison to our peers and for acute inpatient care – we are leading the province. For 2014-2015, the focus of improvement will be in two areas – Mount Hope Centre for Long Term Care and mental health. Planned initiatives in mental health include rounding with patients, lean review of clinical processes on the units, implementation of recovery oriented practice changes and implementing strategies to foster a welcoming environment for patients and families. At Mount Hope Centre for Long Term Care, initiatives will be focused on enhanced communication with residents and families, improved recreational activities, resident rounding and responsiveness to resident's needs.

Ministry of Health and Long-Term Care Recommended Indicators for QIP

The Ministry of Health and Long-Term Care recommended specific indicators for inclusion in an organization's QIP. Seven recommended indicators were to be included in an organization's QIP if they were applicable and if performance was not at a desired level. The seven indicators were:

- C-difficile
- Medication reconciliation at admission
- Hospital total margin
- 90th percentile ED length of stay for admitted patients
- Patient satisfaction
- Alternate level of care
- 30-day readmission to any facility for specific Case Mix Groups (CMGs)

Two of the recommended indicators are included in our QIP – medication reconciliation at admission and patient satisfaction. Two of the indicators are not applicable to St. Joseph's - 90th percentile ED length of stay for admitted patients since St. Joseph's does not have an emergency room and 30 day readmission rate for specific Case Mix Groups since St. Joseph's does not care for the patient groupings included in this indicator. For the remaining three indicators (c difficile, hospital total margin, and alternate level of care – acute), St. Joseph's performance is at a desired level and is not a focus for quality improvement in 2014-2015.

Integration & Continuity of Care

Achievement of our strategic priorities is not possible without working collaboratively with our healthcare partners. Improved integration and continuity is a specific outcome of our HUGO initiative outlined above. HUGO is being implemented at several regional hospitals. This allows consistent information on medications to be available to all service providers and supports safer continuity of care when patients are transferred between hospitals or readmitted to a hospital. It also facilitates clearer and more standardized discharge prescriptions to improve continuity of care into the community. Falls reduction and prevention strategies avoid injuries that may result in transfer to acute care hospitals and provide patients and families with knowledge and education that allow them to be discharged to the community safely.

Challenges, Risks & Mitigation Strategies

For all initiatives, it will continue to be a challenge to implement changes required to achieve our targets in light of limited financial and human resources. This work requires agreement and collaboration with multiple parties and stakeholders. To ensure success, we are actively engaged in this work with our partners to improve quality and patient safety in our community. We have set aside strategic investment funds that allow us to focus resources on our key priorities. The implementation of HUGO is one of the most significant changes in clinical care delivery that has required major organizational engagement of multiple stakeholders. Many of the risks have been mitigated by notable stakeholder engagement, dedicated resources to support the work, and implementing HUGO in smaller regional hospitals to first learn from them prior to implementing in our larger organizations.

Information Management Systems

A key priority for our organization in 2014-2015 is the implementation of HUGO which involves implementation of:

- Computerized Provider Order Entry
- Electronic Medication Administration Record
- Closed Loop Medication Administration
- Electronic Medication Reconciliation

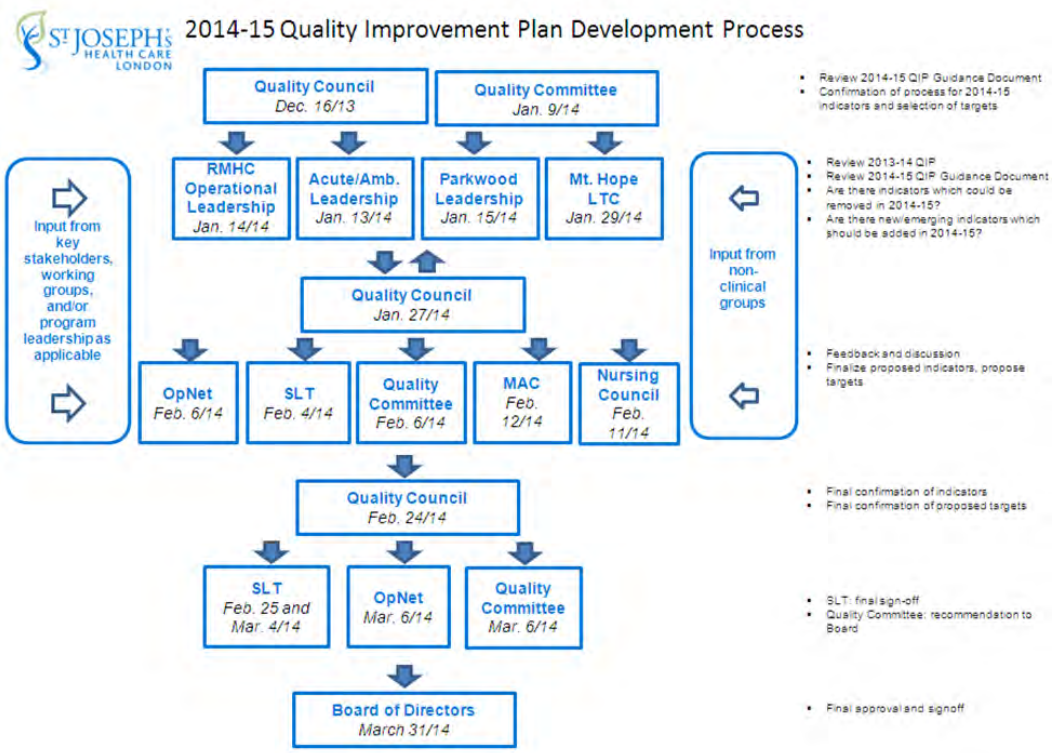
This is one of the most complex information system implementations that the organization has embarked on and involves an enhancement to our information systems to drive patient safety in a completely different way than ever before. In addition to the above, our organization has implemented a case-costing system that brings together several data sources and will allow us to benchmark and identify efficiencies. We are also actively involved and/or leading several collaborations within and outside of our Local Health Integration Network to improve the sharing of information among care providers in order to support and enhance coordination of care.

Engagement of Clinical Staff & Broader Leadership

St. Joseph's has a very structured and collaborative approach to determining its strategic quality improvement priorities for the organization. The organization has a three year strategic plan that has four main goals focused on patients. They are:

- Be a national leader in quality and patient safety
- Provide integrated patient-centred care
- Leverage technology to enhance quality and patient safety
- Achieve annual Quality Improvement Plan (QIP) objectives

In terms of development of our annual QIP priorities, St. Joseph's process involves physician, operational, senior leader and board engagement (see diagram below).



Accountability Management

Leaders at St. Joseph's at all levels (coordinator, director, senior leader) have clearly established goals for 2014-2015 and where applicable, goals are aligned with QIP priorities. Targets, 90 day plans, and monthly tracking of progress will be conducted with leaders.

Links to performance-based compensation

Our executives' compensation is linked to performance in the following ways:

- St. Joseph's President and Chief Executive Officer (CEO) has five per cent of her annual salary compensation at risk related to achievement of annual Quality Improvement Plan indicator targets outlined below.
- All senior leaders (leaders reporting directly to the President and CEO with the exception of the St. Joseph's Health Care Foundation President and CEO) have three per cent of their current annual salary compensation at risk related to the achievement of annual Quality Improvement Plan indicator targets outlined below.
- Integrated senior leaders (those who work at both London Health Sciences Centre and St. Joseph's Health Care London) will have the three per cent of their annual salary at risk split between each organization equivalent to the current cost sharing for their respective roles.
- The President and CEO and senior leaders reporting to the President and CEO will have the same targets.
- The following four indicators will be tied to performance based compensation:
    - Falls with injury
    - Hand hygiene compliance
    - Seclusion and restraint use
    - Medication reconciliation
- Compensation will be awarded as follows:
    - The four indicators carry equal weight (each one is worth 25 per cent)
    - For each indicator:
        - Less than 50 per cent of target achieved = none of the compensation at risk will be awarded for that indicator
        - 50 to 99 per cent of target achieved = compensation at risk will be awarded for that indicator prorated based on per cent of target achieved
        - 100 per cent or more of target achieved = 100 per cent of compensation awarded for that indicator

Indicator	Current	50 Per cent of Target	Target
Hand hygiene *(Moment 1 Hand Hygiene Compliance - based on March 2015 audit results)*	89 per cent (based on Q3 results)	92 per cent	95 per cent
Medication reconciliation at inpatient admission *(Per cent of inpatient admissions where medication reconciliation was completed at admission)*	86 per cent (based on Q3 audit)	90.5 per cent	95 per cent
Falls with injury *(Parkwood Hospital and Mount Hope Centre for Long Term Care combined - quarterly average count)*	137 per quarter (average of Q1-Q3)	130 per quarter	123 per quarter
Seclusion and restraint use in Regional Mental Health Care London and Southwest Centre for Forensic Mental Health Care *(Average quarterly total hours of combined seclusion and restraint use)*	7,136 hours (average of Q1-Q3)	6,779 hours	6,422 hours

Health System Funding Reform

With the introduction of health system funding reform, there has been a move to funding of specific procedures aligned with best practices from a quality and efficiency perspective. In 2013-2014, the relevant procedures for St. Joseph's include cataract surgery, endoscopy procedures, and rehabilitation for primary knee and hip replacements. In the coming year, additional procedures that we may need to consider include specific cancer surgeries, colposcopy, hip fracture rehabilitation and retinal disease. As we have done with prior Quality Based Practices we will work collaboratively with physician leaders to enable best practices and align costs to ensure appropriate outcomes for patients. St. Joseph's is also utilizing the results of Health Based Allocation Model particularly in Complex Care to look at opportunities to provide a high level of care in a more efficient way.

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Margaret McLaughlin
Board Chair
(SIGNED)

Paul Kiteley
Quality Committee Chair
(SIGNED)

Dr. Gillian Kernaghan
President and Chief Executive Officer
(SIGNED)

2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

St Joseph's Health Care London, 268 Grosvenor Street, London

AIM		Measure								Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Patient-centred	**Improve patient satisfaction**	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (per cent excellent) - MOUNT HOPE CENTRE FOR LONG TERM CARE	% / All patients	NRC Picker / 2014-15	714*	11	16	Indicator represents the per cent of patients rating overall care as "excellent" - the highest rating. A 5% absolute improvement in this rating is a clinically meaningful improvement.	Improve	1)Review of nursing and program support teams to build collaborative interventions and activities.	Team Retreat. Standardized program. Build communication accountability with families and care providers.	Retreat and standardized program completed.	Coordinated compassionate care. Decreased number of family concerns about communication.	
										2)Improve patient experience.	Target top three survey questions with highest correlation to overall satisfaction based on 2013 resident survey. Expand weekend activities.	Number of weekend activities.	Increased resident satisfaction with variety and time of program options. Resident satisfaction scores increase.	
										3)Strengthen relationship with Resident and Family Councils.	Create transparency in patient care and financial aspects. Increase reporting at Resident and Family Council as requested.	Number of reports to Resident and Family Council.	Positive partnership with Resident and Family Councils.	
										4)Increased staff engagement.	Leader Rounding. Revise Long Term Care Committee. Establish Shared Leadership Council. Build Quality Circles.	Number of staff rounded. Long Term Care Committee, Shared Leadership Council and Quality Circles implemented.	Engaged workforce delivering compassionate, resident-focussed care.	
										5)Develop clear expectations of resident and family centred experience.	Education of staff on call bell responsiveness, undistracted care, intentional comfort rounding.	Frequency of comfort rounding; percentage of staff who received information on call bell responsiveness.	Improved responsiveness of staff in meeting resident needs.	
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (per cent excellent) - REGIONAL MENTAL HEALTH CARE LONDON AND SOUTHWEST CENTRE FOR FORENSIC MENTAL HEALTH CARE	% / All patients	NRC Picker / 2014-15	714*	8	13	Indicator represents the per cent of patients rating overall care as "excellent" - the highest rating. A 5% absolute improvement in this rating is a clinically meaningful improvement.	Improve	1)Implementation Plan for enhancing the patient and family experience in three phases.	Phase 1 - April 1, 2014 to March 31, 2015.	Percentage of targeted units with implementation of phase 1.	100% of targeted units have implemented phase 1 by December 31, 2014.	
										2)STAFF ENGAGEMENT PHASE 1	Finalize identification of first units for implementation. Planning, evaluation and communication activities.	Number of Units confirmed. Confirmation of communication, training and evaluation.	Identify 5 units by April 1, 2014. Communication to staff, finalize training and evaluation tools by April 30, 2014.	
										3)Use of Patient Story Tool.	Implement Story Tool with unit education session(s).	Percentage completion.	100% complete on five units by July 31, 2014.	
										4)Use of Recovery Star.	Implement Recovery Star Tool with unit education session(s).	Percent completed.	100% complete on five units by September 30, 2014.	
										5)Patient Empathy Facilitators assigned.	Assignments through peer nomination process.	Number of Units with Facilitators in place.	Patient Empathy Facilitators in place on the five units by October 31, 2014.	
										6)Roll out to remaining six units.	Implement tools as noted above.	Percent completed.	100% complete by January 31, 2015.	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
										7)Evaluation of Phase 1.	Focus groups with staff, Patient and Family Councils. Complete patient survey.	Focus groups data collection, analysis and report completed by March 31, 2015. Patient survey completed February 2015.	Focus groups and analysis of results completed. Minimum of 5% improvement in score February 2015 patient survey.	
										8)PROCESS CHANGE PHASE 2.	Roles and responsibilities clarified for all. Development of Team Agreements. Regular Rounding with patients and families. Lean review of clinical processes on inpatient units.	Implementation plan completed.	Some work already underway – details of overall implementation plan to be determined by March 31, 2015.	
										9)ELIMINATING BARRIERS - PHASE 3.	Development of written standards for Recovery Oriented Practice and performance management plan matched with standards. Ensure a welcoming environment.	Written standards and performance management plan completed.	Some work already underway – details of overall implementation plan to be determined by March 31, 2015.	
Safety	**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 (e.g. Q2 2013/14, Q3 2013/14 etc.)	714*	86	95	To improve medication safety by properly reconciling medications used by patients at home on admission to hospital.	Improve	1)Increase compliance with completing medication reconciliation on admission.	Using electronic medication reconciliation process for medication review on admission.	HUGO medication reconciliation completion reports / frequency of review of completion reports.	95% completion rate for medication reconciliation on admission.	
										2)Develop a plan to evaluate the quality of medication reconciliation on admission.	Task force to develop indicators representing the quality of medication reconciliation using a survey tool.	Indicators and a process to report data quality are developed.	To be determined as part of indicator development.	Need to evaluate the quality of the information and process.
	Avoid Patient falls	Number of patient falls per quarter resulting in injury at Parkwood Hospital and Mount Hope Centre for Long Term Care.	Counts / All patients	Hospital collected data / 2014-15	714*	137	123	The target is a further 10% reduction in falls with injury following targets achieved for this indicator in the 2013-14 plan, and is consistent with research and evidence of achievable improvement aligned with best practices being implemented.	Improve	1)Enhance level of communication of falls, falls strategies and successes at corporate and program levels.	Implement communication tools that provide immediate feedback and are visible to teams, i.e. safety cross, dashboards. Expand corporate articles and personal stories. Explore sharing of strategies across programs to enhance collaboration and consistency across Parkwood.	Number of targeted programs / units using a visible communication tool; frequency of updates.	100% of targeted programs/units are utilizing a visible communication tool. Key messages on intentional comfort rounds developed. Nursing Council receiving a quarterly update. Quarterly article. Statistical analysis completed.	
										2)Implement intentional comfort rounds (ICR) at Mount Hope Centre for Long Term Care and sustain ICR at Parkwood Hospital.	Audit of intentional comfort rounds. Documentation completion rate. Coach leaders on achieving outcomes. Patient Feedback.	Number of units with audit and documentation of completion. Number of units with patient feedback completed.	100% of units are completing and have documented intentional comfort rounds at Parkwood and Mount Hope. Patients report 4 Ps are being asked.	
										3)Sustain post-fall reviews on all units.	Post-fall review completed after each fall.	Documentation reviews.	100% of falls have evidence that a post-fall review was completed.	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
										4)Implement e-learning module on falls prevention for non-clinical teams.	Revise e-learning module for identified non-clinical staff.	Number of staff with completion of e-learning module.	90% of clinical staff completed e-learning module. Self-report of improved knowledge of falls prevention from staff completing e-learning module. Completed e-learning for identified non-clinical staff at Parkwood and Mount Hope 50% compliance March 2015.	
										5)Explore new strategies and technologies for falls injury prevention and assessment in Long Term Care and Veterans Care.	Review complete.	Completed review.	Identify any new evidence in literature to reduce falls in frail elderly.	
										6)Parkwood Hospital and Mount Hope Centre for Long Term Care will explore other evidence-based strategies to consider (e.g. balance training, etc).	Review of evidence.	Completed review.	Identification of further strategies for implementation.	
										7)Implement falls assessment tool in Mount Hope Centre for Long Term Care in electronic patient record (EPR).	Selection of tool and implementation in the EPR.	Number of units that have implemented falls assessment in EPR.	10 units implemented.	
	Reduce use of physical restraints	Seclusion and Restraint: Hours of seclusion and restraint use at Regional Mental Health Care London and Southwest Centre for Forensic Mental Health Care.	% / All patients	Hospital collected data / 2014-15	714*	7136	6422	The target represents a 10% annual decrease in hours of seclusion and restraint from the current performance, based on the average for Q1-through Q3, 2013-14. The target is a further reduction building on the 2013-14 QIP goals.	Improve	1)Leadership towards organizational change.	Articulate roles and accountabilities of leaders at various levels in the monitoring and review process.	Roles and accountabilities related to monitoring and review completed.	80% compliance with protocols in 2014-15.	**All metrics for this QIP (Goals for change) are draft and require confirmation by the advisory committee.
										2)Leadership towards organizational change.	Create central repository for all completed debrief/reflective practice documents.	Central repository created.	100% of all debriefing/reflective practice documents and results are summarized by fiscal year end.	**All metrics for this QIP (Goals for change) are draft and require confirmation by the advisory committee.
										3)Use of data to inform practice.	In consultation with Quality Measurement and Clinical Decision Support Team (QM&CDS), validation of data to be used to inform practice going forward – including processes for review of same. QM&CDS will conduct a comparative analysis of events entered into the Power Form vs Patient Safety Reporting System (PSRS) events to identify any reporting gaps. Ongoing process for data auditing to be determined. Data reviewed quarterly at Advisory Committee and Operational Leadership.	Number of units with audit completed, follow-up in place for any areas where reporting gaps are identified.	All data elements finalized and reliability audits complete by August 31, 2014. Seclusion and restraint hours reduced to 6,422 on average over four quarters 2014/15.	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
										4)Workforce development.	Finalize core learning content.	Updated training module.	Existing staff training module is updated to incorporate the “patient experience” element by fiscal year end 2014/15.	
										5)Use of seclusion and restraint reduction tools.	Finalize information on alternatives to seclusion that will be incorporated into the strategy.	Tools completed, Q3 audit completed	Process for collection of completed debrief and reflective practice tools is established by August 31, 2014. Monitoring, feedback and reporting process is established and in place by August 31, 2014. 100% of patients have Personal Safety plans completed and on file (initial audit to be completed for Q3 at the Southwest Centre).	
										6)Patient roles in inpatient settings.	Continue to actively involve members from the Patient and Family Councils.	Percentage of meetings with patient representation.	Patient representation at 100% of Advisory Committee meetings.	
										7)Debriefing techniques.	Finalize all de-briefing processes and tools including a tool for Co-patient Debriefing. Create protocols and monitoring processes for each of the tools.	Q4 audits completed.	100% of seclusion/restraint events have a reflective practice document completed (initial audit for Q4 at Southwest Centre). 80% of patient debriefing tools completed with documented rationale when unable to complete (audit as above).	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
	Hand Hygiene Compliance	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100, consistent with publicly reportable patient safety data.	% / staff	Hospital collected data / 2014-15, Q4	714*	89	95	The goal is to further improve on our percent hand hygiene compliance before patient contact and to reach the new target of 95% based on our Q4 audit, based on all inpatient areas including long term care, as well as ambulatory areas at the St. Joseph's Hospital site.	Improve	1)Enhance engagement of all staff in improving hand hygiene compliance.	Leadership rounding with all staff to ensure understanding of importance of hand hygiene and gather staff's ideas as to how to improve compliance.	Rounding log documentation.	Leaders document on rounding logs conversations have occurred with staff.	
										2)Focus on barriers to adopting hand hygiene moment 1.	Ask health care workers to identify the barriers to performing hand hygiene before patient contact and to identify potential solutions.	Number of staff providing feedback.	Health care workers are engaged in identifying barriers. 100% of feasible and evidence-informed improvement strategies specific to their area are adopted.	
										3)Expand focus of hand hygiene to ambulatory care areas and Mount Hope inpatient units.	Inventory measures in place across ambulatory care programs. Leaders to address gaps, and identify evaluation strategy re hand hygiene compliance specific to their areas.	Inventory of ambulatory areas completed.	Include data from auditing hand hygiene compliance at Mount Hope and ambulatory care programs in indicator data by year end.	
										4)Increase support to and linkages between infection safety resources roles within clinical programs and Infection Prevention and Control (IPAC) team members.	Infection Control practitioner (ICP) monthly rounding with infection safety champions and hand hygiene auditors. Quarterly education sessions offered to auditors to refresh skills. Monthly resources offered to ensure quality of audits.	Number of quarterly education sessions and percentage of champions and auditors rounding monthly.	50% of champions and auditors participate in rounding with ICPs monthly.	
										5)Ensure point of care access to alcohol based hand rub (ABHR).	Audits of access to ABHR in ambulatory care areas and Mount Hope, and implement measures to address gaps.	Number of areas with completed audits.	ABHR to be available at point of care for inpatient units at Mount Hope Centre for Long Term Care and ambulatory care areas, confirmed with follow up.	
	Improve medication safety	Medication safety (number of incorrect patients and incorrect drugs per year).	Counts / All patients	Hospital collected data / 2014-15	714*	80	16	Related to our goal of 95% medication reconciliation at admission and related process changes, a target for an 80% reduction in medication errors involving the wrong patient or wrong drug has been set, with a goal of reduction from 80 events to 16 events in 2014-15.	Improve	1)Barcoded medications and barcoded patients using a closed loop medication administration (CLMA) process will reduce this type of error.	Healthcare Undergoing Change (HUGO) reports run quarterly (in alignment with Patient Safety Reporting System (PSRS) reports).	Compliance rates for barcoding of medications and barcoding of patients.	80% reduction in reported rate.	Note: current baseline estimate is based on voluntary and self-reporting process. The HUGO environment will "force" or "identify" these types of errors. It is possible that our baseline is underreported.