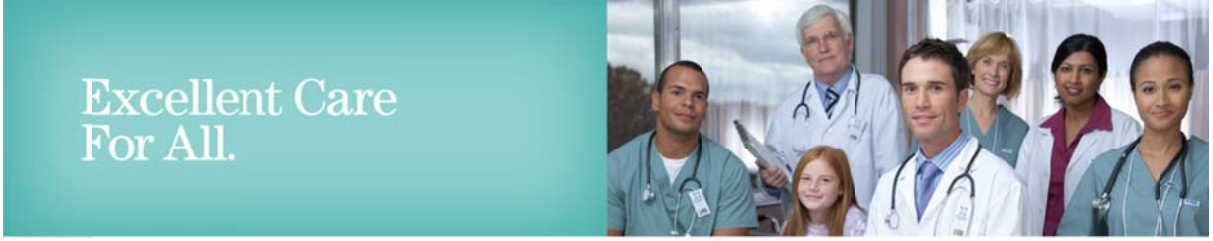

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

MUSKOKA ALGONQUIN HEALTHCARE

Approved by Board of Directors March 14, 2013

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

Overview of Our Organization's Quality Improvement Plan

Overview:

Muskoka Algonquin Healthcare (MAHC) is a two site, acute care community hospital organization located in Huntsville and Bracebridge. The organization has been guided by a Strategic Plan since 2012 that focuses on five overarching dimensions which include: quality care and safety, education and innovation, people, partnerships and collaboration and creating a sustainable future. The Quality Improvement Plan (QIP) is aligned with the Strategic Plan goals and objectives that have been developed in order to achieve the mission of the organization which is to provide outstanding care that is people focused. The QIP is also closely aligned with the organizational values which highlight the need to be engaged in, and accountable for quality, patient centered care. In addition, the organization is also sharply focused on the need for transformational change in order to continue to drive patient and provider safety along with quality outcomes. The QIP for 2013/14 reflects both the need to prepare for change as health system funding reform becomes a provincial priority and also the extensive commitment that has been made specifically around quality care and safety. In fact, fifty percent of the QIP 2013/14 objectives fall under the dimension of safety. The plan is also aligned with the need to focus on quality based procedures (QBPs) as they are introduced provincially.

There is an ongoing commitment to continue to improve in areas that have been the focus of quality improvement during prior QIP submissions. It is also reflective that continued and consistent focus on objectives for consecutive years promotes performance excellence and transformational quality care.

Focus:

Access - In terms of improving access, MAHC will continue to strive for a reduction in the length of stay for admitted patients in the Emergency Department (ED). The target is very much a stretch target and there have been improvements in the 2012/13 data as compared to the 2011/12 data. Many change ideas have been considered and an investment is being made in developing a patient flow navigator role. Process improvements supported by LEAN methodology will continue in 2013/14. Many of the care coordination improvements have an end goal of "pulling" the admitted patients from the ED to the inpatient bed more quickly thus reducing length of stay in the ED.

Effectiveness - Improvement in organizational financial health, through monitoring of the total margin, is a key objective in the 2013/14 QIP. A major initiative is underway to ensure future viability and sustainability of the organization. The project entitled *Closing the Gap* focuses on transformational changes that will be required to remain efficient and effective. The initiatives are designed to ensure organizational energy and capacity is aligned and optimizes organizational ability to maximize safe quality health care.

Integrated - Based on transformational changes that will be occurring in the organization in 2013/14, the reduction of alternate level of care (ALC) patient days remains a top organizational priority. Building on the success of 2012/13, in terms of ALC day reduction, a number of improvement initiatives are planned. Some of these changes involve an increase in the support required to help with safe transitions to other environments like the patient's home. Examples of these supports include enhanced rehabilitation and mobilization. An initiative entitled *Care to Discharge* is being piloted and this will ensure immediate focus on removing barriers and challenges that may have the end result of a patient becoming ALC and increasing length of stay.

Reduction of unnecessary hospital readmissions is targeting one of the top MAHC case mix groups and is aligned with a QBP for 2013/14. Chronic obstructive pulmonary disease (COPD) will be targeted for a nineteen percent reduction in readmissions and improvement in the overall continuum of care based on the 2011 Ministry of Health document entitled "Enhancing the Continuum of Care". This readmission reduction will be achieved through: alignment with medical staff accountability and partnerships, care pathway development, Health Quality Ontario's evidence based practice review and new patient teaching programs like "Ask Me Three" and teach back.

Patient Centered - Patient satisfaction will continue to be monitored through NRC Picker surveys. Overall excellent results, based on peer hospital benchmarks, are an organizational priority. In 2013/14 there will be an increased focus on inpatient satisfaction. An area of significant attention and change initiatives will be patient teaching and preparation for discharge.

Safety - There are five important objectives in the safety dimension of the 2013/14 QIP. Some of these, such as hand hygiene, and the reduction in hospital acquired C-difficile infections (CDI) have been targeted for improvement in prior QIPs. The organization is committed, through new and ongoing initiatives, to continue to show improvement in these two areas of focus.

There will also be three new safety objectives in the 2013/14 QIP. These have been selected because they are synergistic with other objectives and have important quality and safety ramifications for patients. The three new objectives are; medication reconciliation, antibiotic stewardship and an increase in the number of discrete measurable quality and safety improvements completed during the year.

Medication reconciliation is aligned with Accreditation Canada standards and may also improve length of stay and reduce readmission rates. Infrastructure in terms of information technology, human resources and improved tracking are change ideas currently being implemented.

Antibiotic stewardship will be an enabler for success in most safety initiatives like readmissions and CDI. An antibiotic advisory committee has been struck and is working on implementation of many standard order sets and promoting best practice in terms of antibiotic usage.

A necessary underpinning for quality and safety is a cultural foundation focused on continuous improvement. Implementing increased accountability at the unit level for measurable quality improvement throughout the organization will promote a cultural shift and will provide traction for all of the QIP initiatives.

Alignment:

Alignment is essential to ensure that organizational energy is focused and synergistic. The QIP is aligned with both organizational and provincial priorities. Currently MAHC is undergoing capital/master planning and the future vision for the organization will only be achieved through efficient, effective quality care. Funding sources like Pay for Results are another critical element required for organizational sustainability and success. Initiatives and objectives have been aligned to help meet targets that enable key performance metrics. The organizational priorities embedded in the strategic plan are reflected in the quality improvement objectives and initiatives in the QIP. Key documents like the patient safety plan and the balanced scorecard are intertwined with the quality improvement plan so that key metrics are always in clear focus and are transparent. Various QIP indicators, such as health care acquired infection rates and ED wait times, are also aligned with accountability agreements, for example the Hospital Services Accountability Agreement.

Integration and Continuity of Care:

MAHC has demonstrated a strong history and clear commitment to work with partners to ensure quality care across the continuum. An excellent example is the Seniors' Assessment and Support Outreach Team (SASOT) housed within the hospital but focused on care coordination of frail seniors in their home environment. This team works closely with the CCAC and has shown favorable results in decreasing ED visits, ALC rates and improving inpatient length of stay. The plan also takes into consideration the importance of partnering externally to ensure the most accurate patient information is available at each transition of care. Medication reconciliation is a good example of this type of information sharing.

Partnering is a key ingredient in maximizing our discharge processes and these partnerships include but are not limited to primary care, pre-hospital care, community care, other hospital organizations, pharmacies and broad system partners like the Local Health Integration Network.

Health System Funding Reform (HSFR):

Successful organizational integration of health system funding reform into operations and care practices will be dependent on a culture that is focused on quality, process improvement and on the ability to manage change. The MAHC 2013/14 QIP has been structured to help the organization adapt to a patient based funding system. Care coordination in the LHIN is a top priority and MAHC is a strong supporter of and advocate for the "Care Connections" philosophy and action plans.

The objective, to decrease the percentage of COPD readmissions, is a specific example of how the organization is positioning itself to meet Quality Based Procedure (QBP) benchmarks. Perhaps most important is the overall organizational quality focus and process improvement focus that is a consistent message throughout the organization. While each initiative can benefit a certain care or business process it is the unrelenting focus on continuous improvement that will aid in changing culture.

Each care committee has been charged with ensuring that evidence based practice is being achieved and priorities have been agreed to, based on what QBPs are being introduced. Investments in decision support have allowed MAHC to ensure that key data is communicated in a timely manner so course correction can be nimbly achieved.

Challenges, Risks and Mitigation Strategies:

One of the major challenges to the success of the QIP objectives will be stakeholder engagement. It will be necessary, during a time of health care reform in Ontario, for the organization and all care providers, both internal and external to be committed to moving the quality agenda forward ongoing. Investments must be made in infrastructure at MAHC. The information technology required to embed and monitor evidence based practice is essential and this is a current organizational priority. MAHC also continues to make investments in physical plant redesign and renovation to enable improved patient and provider safety.

The major risk to achieving all of the QIP objectives will be the inability to engage stakeholders and the inability to meet the financial commitments required for quality improvement initiatives that require investment. Meeting funding targets may also result in impacts on some services that may have negative effect on QIP metrics such as Access.

The crucial mitigation strategy will be the organizations' ability to be transparent and timely with communications. It will also be important that accountabilities for meeting QIP targets are embedded in pay for performance and personal business commitments. Each person, whether they are a clinical provider or a support person, must understand they have a role to play in providing quality patient care.

Link to performance based compensation:

Business Commitments are tied to Muskoka Algonquin Healthcare's (MAHC) Quality Improvement Plan (QIP), the MAHC Board endorsed 3-Year Strategic Plan, The North Simcoe Muskoka Local Health Integration Network's "Care Connections" 10-Year Plan, and impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2013-2014 Personal Business Commitments. Clearly Health Funding Reform and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance and the patient experience and the need for integration and partnerships are key drivers to positioning not only MAHC, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per MAHC's approved Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

- Quality: 50% weighting
- Financial: 30% weighting
- Strategic: 20% weighting

Accountability Sign-off

I have reviewed and approved our organization's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*.

Larry Saunders	Charles Forret	Natalie Bubela
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*

Our Improvement Targets and Initiatives

Please complete the Improvement Targets and Initiatives spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital's website.

[Please see the *2013/14 QIP Guidance Document for Ontario Hospitals* for more information on completing this section.]

Part B: Improvement Targets and Initiatives 2013/14 for Muskoka Algonquin Healthcare, 100 Frank Miller Dr., Huntsville, ON P1H 1H7

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**	**Comments**
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	22.30	8.00	Aligned target with P4R target.	1	**1**	Pilot a patient flow navigator for each site	Number of patient flow navigators in place	Two patient flow navigators on staff	Patient Navigation will enhance patient flow.
							2	Increase private room capacity in clinical inpatient care areas.	Number of private rooms available in the inpatient clinical areas	To facilitate ease of admission, an improvement of 10% of inpatient rooms will be private.	Increased private rooms will allow for easier ability to admit patients into inpatient bed areas
							3	Optimize bed availability through a targeted approach to decrease readmission demand for two of the top CMG's - COPD and Pneumonia.	Monitor readmission rates for COPD and Pneumonia CMG.	Decrease readmission rates for the Pneumonia and COPD CMG to 10% or less.	Decreased readmission rates reflect improved quality of care and allow the organization to maximize the utilization of our acute beds.
Effectiveness	Improve organizational financial health	Total Margin (consolidated): Percent, by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2012/13, OHRS	0.53	1.00	Continue to improve organizational financial health. Prepare for HSFR and QBP's.	2					
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2011/12 – Q2 2012/13, DAD, CIHI	26.79	25.45	Continue to reduce percentage of ALC days for acute care by 5% per year until best achieved to date in Ontario is reached.	1	**1**	Pilot a patient flow navigator at each site to initiate discharge planning at time of admission and enhance the continuum of care	80% of admitted patients will have an assessment by the patient flow navigator. The discharge checklist will be initiated for those with a Lace score of 10 or >.	Optimize discharge planning from the time of admission.	The goal is a reduced LOS and appropriate, comprehensive discharge planning to prevent readmission.
							2	Review Patient Care Plan and change focus to one of "care to discharge" at one site. Trial for 6 months and monitor LOS and ALC rates at that site. Spread to the other site if a successful initiative, and plan for sustainability of the initiative from the start of the project.	Number of patients admitted where the "new trial" Patient Care Plan is utilized. LOS for patients on the trial unit. Percentage of ALC days for patients admitted to the trial unit	Quality Improvement project to improve "care to discharge" through the use of a Patient Care Plan.	A structured approach (Patient Care Plan) will reinforce the importance of "care to discharge".
							3	The Seniors Assessment and Support Outreach Team (SASOT) program is in place at one site. Ongoing commitment to support and monitor the effectiveness of SASOT on decreasing ALC rates. To date this program has had a positive effect on our acute ALC rates and has assisted MAHC to meet our target for 12/13. The organization will assess the feasibility of	Number of patients who have accessed and participated in the program Number of visits by SASOT staff ALC rates/ED visits/LOS for SASOT clients	Assists seniors to return home safely, as soon as possible, with additional supports.	The MOHLTC and the NSM LHIN provided financial support to develop and implement the SASOT Program at one site of the organization. Other funding opportunities to "spread" and further enhance existing services will be explored.

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Initiative Number	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for change ideas (2013/14)	Comments
								spreading this initiative to the other site or implementing a home support process in parallel to existing community supports.			
		Reduce unnecessary readmission rate for the COPD CMG- one of the top users of MAHC resources and a QBP for 13/14	12.37	10.00	Decrease readmissions for the COPD CMG and strive toward best achieved overall (all CMG's) readmission rates for the province (9-9.84%)	1	**1**	Enhance the continuum of care by instituting the "Safe Discharges Practices for Hospitals Checklist".	Number of admitted COPD patients with a high risk readmission LACE Score of ≥10 that the checklist is implemented on.	80% of COPD patients with a Lace Score of ≥10 will have a discharge checklist completed.	Optimize transitions in care for COPD patients, one of our top admission CMG's, to prevent readmission and optimize the quality of care provided by MAHC.
							2	Standard Order Set	Compliance with use of a Standard Order Set for this admission CMG.	80% compliance with Standard Order Set utilization	Standard Order Set compliance will optimize that MAHC patients with a COPD admission diagnosis receive best practice, safe, quality care.
							3	Implement LACE Index readmission prediction tool to assess risk of readmission for COPD patients.	100% compliance with the tool usage to assess inpatient risk of readmission for this CMG (COPD).	Identify 100% of COPD patients at high risk for readmission and enhance transitions of care.	Maximize the identification of those patients that are at high risk for readmission for this CMG and optimize measures in place to facilitate their safe transition back to their home and decrease the risk of readmission.
							4	Discharge Medication Reconciliation	Number of discharge medication reconciliations completed for this CMG. Number of education sessions with patients on how to properly use discharge medications and how they relate to the medications they were on when they were admitted.	100% of COPD patients with a Lace Score of ≥10 will have discharge medication reconciliation.	Improper medication practices post discharge is a leading factor in readmission and adverse events post discharge.
							5	Implement a Smoking Cessation Program at MAHC for Inpatients	COPD admissions will be assessed for smoking habits and the "Ottawa Model" for smoking cessation will be utilized to assist these patients with smoking cessation.	80% of COPD patients admitted who smoke will be offered an intensive smoking cessation intervention.	HQO endorses evidence-based strategies aimed at encouraging smoking cessation in patients with COPD. Intensive counseling (≥90 minutes) is the most effective and cost-effective strategy, and should be encouraged.
							6	Patient Safety Cultural Improvement Project focusing on point of care communication in the inpatient med/surgical clinical areas to improve patient safety culture, quality of care and decrease readmissions.	Number of safe quality days, number of quality improvement actionable items and number of learning opportunities shared on the units.	Improve the safety climate of the units; strengthen teamwork, communication, patient outcomes.	
							7	Incorporate accountability into Medical Lead	Share readmission rates broadly across the medical	Shared responsibility and engagement across the	This shared accountability will assist MAHC to bridge the quality

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Initiative Number	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for change ideas (2013/14)	Comments
								performance expectations.	staff/program committees to ensure engagement, partnership and accountability for this quality indicator.	organization for this quality indicator	gap and strengthen our ability to ensure that the highest standards of care are provided by all practitioners.
							8	"Ask Me 3" program to facilitate patients to actively advocate for information around their care and to facilitate patient understanding of their main healthcare problem, what they need to do for that problem and why action is important. MAHC will utilize "teach back" methods to ensure that patients have a comprehensive understanding and recall of all information shared.	Number of documented patient educational opportunities provided for COPD patients based on the "Ask Me 3" content and the utilization of "teach back" practices.	Improved patient safety and patient-centred care.	
							9	High Risk LACE score (≥10) COPD patients will also receive a follow up phone call within 7 days of discharge by patient flow navigator.	Number of LACE Score COPD patients that receive a post discharge phone call within 7 days.	That 100% of high risk LACE Score COPD patients will receive a post discharge phone call.	
Patient-centred	Improve Patient Satisfaction	From NRC Picker/HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely")	71.42	82.00	Focus on inpatients and our ongoing commitment to patient-centred care	2					
	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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13).	74.50	90.00	This is a key patient safety metric and project at MAHC. A stretch target has been set for the organization.	1	**1**	Improve the process of BPMH (Best Possible Medication History) on admission and implement change ideas recommended from the sub-committee tasked with making improvements and streamlining the issues identified over the last year.	Improved accuracy of BPMH. Improved tracking of compliance.	Meeting the stretch target for compliance	
							2	Explore IT infrastructure improvements to facilitate ease of implementation and accuracy for BPMH and monitoring of compliance.	Implementation of an Electronic Health Record across the organization as per the Strategic Plan.	A fully computerized system in place by the end of March 2014.	An electronic-based patient health record and medication record will facilitate improved medication reconciliation and the accuracy of the process.
							3	Align resources with this organizational priority to ensure success of meeting target.	Resources are aligned to ensure success of this indicator.	Department is resourced with staff and tools to enable stretch target compliance.	

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**	**Comments**
	Increase the number of measureable quality/safety improvements per year.	The number of measureable quality/safety improvements implemented across the organization to eliminate waste and improve efficiencies.	22.00	200.00	Drive LEAN initiatives and quality and safety improvements as leader standard work embedded in daily practice, in all areas of the organizations.	2					
	Optimize appropriate antibiotic usage	Readmission rate for pneumonia CMG	12.19	10.00	Reduce defects or readmissions	1	**1**	Share quarterly readmission rates across the organization and align accountability for this indicator with the medical staff/program committees.	Number of program/medical committees the data is shared with. Number of readmissions that had a chart review	Accountability and alignment with medical staff/program committees to bridge the quality gap.	
							2	Approval of a Standard Order Set and compliance with usage.	Number of Standard Order Sets used for patients admitted with pneumonia.	80% compliance with standard order set usage.	To maximize adherence to best practices, the Standard Order Set should be implemented and utilized across the organization.
							3	Measurement of the costing for the top ten antibiotics used at MAHC.	Costing on the top ten antibiotics in use at both MAHC on a quarterly basis.	Understand the costs of our antibiotic usage and target a reduction of 10%.	Reduced costs should reflect more appropriate antibiotic choices(less broad spectrum) and less overall usage or amounts.
							4	Initiation of a metric to monitor antibiotic usage at MAHC that aligns with our regional partners and provincially. Days of antibiotic therapy (DOT) will be the metric used.	Days of therapy (DOT) for antibiotics with be captured and shared monthly. Share our data with our regional partners at the regional antibiotic stewardship committee.	Understand our antibiotic days of therapy and target a reduction as well as enable MAHC to benchmark.	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, and multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data.	0.23	0.17	Ongoing organizational priority to continue to improve our CDI rate toward the ultimate target of 0. This target is moving MAHC toward the median rate for hospitals with <100 beds.	1	**1**	Ongoing support for a regional Antibiotic Stewardship Program with the support of the NSM LHIN.	Ongoing attendance, engagement and participation at the regional Antibiotic Stewardship Committee. MAHC"s Antibiotic Advisory Committee is established and moving toward meeting core objectives. Initiate collection of data across the region for Days of Therapy (DOT) to enable regional benchmarking. Participate in the IT infrastructure development RE: ASP computer program that will enable the acute care facilities across the NSM LHIN to communicate	To have in place a funded and functional regional Antibiotic Stewardship Program.	Maximize antibiotic stewardship activities as a key component/strategy to affect our CDI and pneumonia readmissions rates.

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Initiative Number	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for change ideas (2013/14)	Comments
									electronically and share a common database and facilitate a regional program for ASP.		
							2	Review order sets that include antibiotic usage at our Antibiotic Advisory Committee (AAC). Review appropriateness of revisions and additions to minimize risks associated with antibiotic use.	Number of order sets, with antibiotics, reviewed by the AAC. Number of changes to order sets that include an antibiotic component.	100% of order sets with antibiotics will be reviewed at MAHC over the year.	Optimize appropriate antibiotic usage for the organization and minimize the risk of adverse outcomes, like to development of healthcare acquired CDI.
							3	Ongoing commitment to improve physical infrastructure to maximize infection control practices to decrease the potential for hospital acquired infections and transmission.	Ongoing commitment to maximize the cohort of private rooms available at each of our sites. All renovation projects will include the active participation of Infection Control to ensure compliance with standards is maximized.	Increased capacity for private room admissions and improved physical infrastructure.	
		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 - Jan-Dec. 2012, consistent with publicly reportable patient safety data.	83.14	87.30	Ongoing organizational commitment to hand hygiene with a continued focus on the before patient contact metric.	1	1	Integrate accountability to providers on their personal performance for this indicator through the sharing of "Hand Hygiene Compliance Report Cards" monthly across the organization and provider categories.	Number of report cards provided to providers Number of report cards provided to managers for performance reviews, known at MAHC as "Performance Excellence" Monitor and share monthly compliance rates by site, department and provider categories.	To ensure that everyone owns and is accountable for safety and quality at MAHC.	
							2	Plan an annual campaign for the month of August to showcase the importance of Hand Hygiene and our commitment as an organization to everyone has "A Role" in stopping the spread of infection.	Completion of one annual campaign.	Reinforce ongoing organizational commitment and the responsibility for quality as everyone's role.	
							3	With each renovation project ensure the physical infrastructure is upgraded to facilitate compliance with hand hygiene and alignment with the most current CSA standards (z8000).	Number of Z8000 dedicated hand hygiene sinks installed at each site by March 31, 2013.	Increase the capacity of dedicated hand hygiene sinks and maximize the ease of compliance.	Older physical infrastructure that requires improved access to dedicated Hand Hygiene sinks.