

## Access and Flow

### Measure - Dimension: Timely

Indicator #18	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of LEAN-FMEA completed.	C	Number / N/a	Frontline staff participants / 2026-2027	1.00	1.00	The UOHI Quality Team conducts 1-2 annual Failure Modes and Effects Analysis (FMEA) within a program or department to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

### Change Ideas

Change Idea #1 Establish a value stream map through consultative meetings with representatives from CT and MRI by March 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Completion of value stream map.	1 Value Stream Map.	This is a continuation of work completed on the 2025-2026 QIP.

Change Idea #2 Develop project plan and share it with the unit by March 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Completion of project plan.	1 project plan provided to unit.	This is a continuation of work completed on the 2025-2026 QIP.

**Measure - Dimension: Timely**

Indicator #19	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of transplant patients enrolled in Cardiac Rehabilitation.	C	% / Transplant Patients	EMR/Chart Review / 2026-2027	CB	CB	Cardiac prehabilitation has been shown to improve functional capacity and decrease hospital readmission in patients with heart failure.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 Develop 1 'patient journey visual pathway'.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	'Patient Journey Visual Pathway' tool developed by February 28, 2027.	'Patient journey visual pathway' documents developed.	

Change Idea #2 Understand patient experience in the rehabilitation program by collecting patient satisfaction through 6-month and 12-month surveys.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Patient Experience Survey at 6 and 12 months post-enrollment.	2 Patient Experience Surveys completed.	

**Measure - Dimension: Timely**

Indicator #20	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Optimization of Digitized UOHI Hypertension Guide	C	Number / Hypertension Guide Users	In-house survey / 2026-2027	15.00	50.00	Validate acceptability and uptake before selecting additional guides to expand pilot.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

**Change Ideas**

Change Idea #1 The project team will gather feedback from 50 users.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Capture feedback from 50 users by April 1, 2026.	50 users submit feedback.	

Change Idea #2 Assess acceptability and uptake through evaluation of user feedback.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Assess acceptability and uptake by September 30, 2026.	1 completed analysis.	

**Measure - Dimension: Timely**

Indicator #21	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve discharge efficiency for cardiology patients on H5.	C	% / Cardiology Patients on H5.	EMR/Chart Review / 2026-2027	CB	30.00	Improving discharge planning reduces unnecessary delays and enhances patient experience.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 Implement a structured discharge readiness and escalation process.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	% completed discharges before 12PM.	30% discharges occur before 12PM.	

Change Idea #2 Standardize discharge documentation and pathway.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	% of patients with EDD entered within 24 hours of admission.	90% EDD entered within 24 hours of admission.	

## Equity

### Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Green Heart Initiative	C	Number / Audits	In house data collection / 2026-2027	2.00	2.00	The UOHI has made environmental stewardship a priority on its new 5-year Strategic Plan.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

### Change Ideas

**Change Idea #1** Conduct one walk-through evaluations for each of the H4 and Cardiac Rehabilitation (Track) units to observe opportunities to optimize recycling and divert waste. The results will be presented to the unit staff, leaders and senior management by March 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Recommendations provided.		<ul style="list-style-type: none"> <li>• 2 Walk-throughs completed.</li> <li>• 2 Report of recommendations for waste diversion and optimized recycling Provided.</li> <li>• Staff education on “How to do your part” distributed.</li> </ul>

**Measure - Dimension: Equitable**

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Accessibility Baseline Assessment	C	Number / Assessment	In-house survey / 2026-2027	CB	1.00	A complete baseline analysis is required to quantify accessibility gaps and inform actionable, evidence-based technology and workflow improvements. Essential to meet AODA accessibility expectations.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

**Change Ideas**

**Change Idea #1** Conduct an organization-wide accessibility baseline assessment to identify physical, digital, communication, sensory, cultural, and procedural barriers experienced by patients, families, staff, physicians, learners, and volunteers by October 2026.

Methods	Process measures	Target for process measure	Comments
Use standardized tools to assess physical, digital, communication, sensory, and procedural accessibility.	% of departments completed using the standardized assessment tool.	100% of departments completed using the standardized assessment tool.	

Change Idea #2 Develop a prioritized list of accessibility gaps identified through the baseline assessment, using criteria such as patient and staff impact, safety risk, feasibility, regulatory requirements (AODA/HSO), and alignment with organizational Equity & Inclusion goals by October 2026.

Methods	Process measures	Target for process measure	Comments
Use standardized tools to assess physical, digital, communication, sensory, and procedural accessibility.	Accessibility barriers identified across all domains.	1 list of barriers identified.	

## Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Culturally-Sensitive Inuit Education	C	Number / Infographic	Patient Partners and External Collaborators / 2026-2027	CB	1.00	Cardiovascular Rehabilitation continues to explore in partnership with the Government of Nunavut, Larga Baffin and Inuit patients around appropriate cardiac rehab and education programs for the Inuit/Northern population.	Larga Baffin, Government of Nunavut

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

## Change Ideas

Change Idea #1 The project team will work together with Inuit patients and an Inuit illustrator to develop a cardiac risk factor infographic poster by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Engage with Inuit patients who attend cardiac rehabilitation, at Larga Baffin, and the Nunavut Government to determine content for the Infographic and to assist in developing visual components with an Inuit illustrator.	Infographic on heart disease risk factors.	1 Infographic on heart disease risk factors.	

**Measure - Dimension: Equitable**

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
EMPaCT in Patient Engagement: Phase 2	C	Number / Stakeholders	In house data collection / 2026-2027	CB	CB	The UOHI has made equity, diversity and inclusion a priority on its new 5-year Strategic Plan.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 Identify three UOHI champions for change among UOHI leadership to assist in advancing EMPaCT framework at UOHI.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Identify Champions for Change within UOHI leadership and operational structure.	3 Champions for Change identified.	

Change Idea #2 Identify a department that will become an early adopter of the EMPaCT model and begin to lay the groundwork.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Identify early adopters at UOHI.	1 Early Adopter department identified.	

Change Idea #3 Identify one stakeholder community to form a UOHI EMPaCT community table by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Identify potential stakeholders for a community UOHI EMPaCT Table.	1 Potential Stakeholder identified.	

## Measure - Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Kairos Blanket Exercise Training	C	Number / Exercises	In house data collection / 2026-2027	1.00	1.00	With the Kairos Blanket Exercise, UOHI aims to create a more inclusive and respectful environment, aligned with the principles of Truth and Reconciliation. Build cultural competency and awareness among staff and Enhance equity, diversity, and inclusion (EDI) initiatives.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

## Change Ideas

**Change Idea #1** The UOHI will arrange for Kairos Canada recommended facilitators to conduct at least 1 blanket exercise for both management and frontline staff by March 2027.

Methods	Process measures	Target for process measure	Comments
Track participation through blanket registration forms	• Training Provided. • Post-training participants feedback.	• 1 training provided • Participants feedback collected	

## Experience

### Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	74.35	76.00	The NP role is new to UOHI and adjustments are an expected phase of monitoring success and supporting new staff.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

## Change Ideas

Change Idea #1 Leadership will collaborate closely with the Nurse Practitioner group to research, define, and select KPIs that will guide future adjustments and measure impact by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	<ul style="list-style-type: none"> <li>Complete environmental scan and research.</li> <li>Select data sources.</li> <li>Finalize chosen KPIs.</li> </ul>	<ul style="list-style-type: none"> <li>100% completed.</li> <li>100% selection of data sources.</li> <li>Minimum 2 KPIs selected.</li> </ul>	<p>Total Surveys Initiated: 3422</p> <p>Nurse Practitioners are new to UOHI.</p>

**Measure - Dimension: Patient-centred**

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Peer Mentor Program	C	Number / Assessments and Additional Cardiac Care Areas	In-house survey / 2026-2027	1.00	1.00	The Peer2Peer program was piloted in Cardiac Surgery in FY 2025-26. When learning about the Cardiac Surgery Peer2Peer Support pilot, other care area leaders reached out requesting more information for expansion, so there is appetite for this type of program across UOHI.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

**Change Idea #1** Assess the success of the Peer2Peer pilot program in cardiac surgery and make adjustments as needed to improve the experience of mentors and mentees by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	<ul style="list-style-type: none"> <li>Satisfaction survey results assessed.</li> <li>Areas of improvement identified.</li> </ul>	<ul style="list-style-type: none"> <li>Complete review and analysis of 1 round of satisfaction survey results.</li> <li>1 round of adjustments based on satisfaction survey results.</li> </ul>	

Change Idea #2 Identify one additional area of cardiac care to expand the Peer2Peer program by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Peer2Peer program expansion identified.	1 additional cardiac care area identified for expansion of Peer2Peer support program.	

### Measure - Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
ROSC Education Class	C	Number / ROSC Patients	EMR/Chart Review / 2026-2027	CB	CB	UOHI has developed a ROSC care pathway on a previous QIP, and is at the stage of implementing further support for discharged patients.	

Is this indicator related to:

Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

### Change Ideas

Change Idea #1 Collect 50 surveys within the first 6 months of the pilot and complete an analysis for opportunities to improve the program by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Analysis of 50 survey responses complete.	Completed analysis of 50 survey responses collected over 6 months.	

**Measure - Dimension: Patient-centred**

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication Boards in CCU and CSICU at UOHI	C	Number / CSICU Patients	Patient Partners and CSICU Staff / 2026-2027	CB	CB	Communication boards for ventilator-dependent and other patients who cannot communicate verbally in CSICU are not used often, or inconsistently. An inability to communicate effectively with patients creates negative experiences for both patients and the healthcare team.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

**Change Idea #1** Develop and pilot a CSICU Communication Board co-designed with Patient Partners and nursing staff, including pictograms and structured feedback tools for RNs and patients/families to assess usability and effectiveness by June 1, 2026.

Methods	Process measures	Target for process measure	Comments
Bi-monthly reporting to the Patient Partnership Council.	<ul style="list-style-type: none"> <li>Draft a template Communication Board for critical care with Patient Partners.</li> <li>Staff surveys.</li> <li>Patient and caregiver interviews.</li> </ul>	<ul style="list-style-type: none"> <li>One final Communication Board approved for deployment to all patient rooms in CSICU.</li> <li>20 nurse responses to RN feedback survey.</li> <li>5 Patient/Caregiver interviews to gather feedback.</li> </ul>	

**Measure - Dimension: Patient-centred**

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient Resources Review	C	Number / Reports	In house data collection / 2026-2027	CB	CB	Determine use of resources by patients and caregivers of each area.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 Record which educational materials are re-stocked over a 6 (September 30, 2026) and 12 month period (March 31, 2027).

Methods	Process measures	Target for process measure	Comments
Quarterly reporting to the Patient Educational Materials Task for and Patient Partnership Council, and to the Patient Education Centre Committee.	Completed reports on re-stocking at the 6 and 12-month marks for each unit.	• 1 report provided to stakeholders at the 6-month mark. • 1 report provided to stakeholders at the 12-month mark.	

## Safety

### Measure - Dimension: Safe

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	100.00	100.00	Maintain compliance.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

### Change Ideas

**Change Idea #1** Once per quarter in this reporting period, the Quality Department will pull a list of discharged patients from H3, H4, H5 and CRC and randomly select 10% of those charts to undergo a spot audit to check for accuracy of discharge medication reconciliation.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of spot audits for reporting period.	1 quarterly spot audit for the reporting period.	

**Measure - Dimension: Safe**

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	2.00	We did not have any time loss in 2025.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

**Change Idea #1** Track rate of lost time due to workplace violence incidents report by hospital workers quarterly in the reporting period.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Quarterly reports.	1 quarterly report of lost time due to workplace violence incidents for the reporting period.	

**Change Idea #2** Track rate of completion of verbal de-escalation and situational awareness training by clerical staff quarterly in the reporting period.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan.	Quarterly reports.	Quarterly reporting of clerical education completion rate.	

**Measure - Dimension: Safe**

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Opioid Stewardship Program	C	Program / All patients	In house data collection / 2026-2027	CB	CB	Accreditation Canada's 2025 Required Safety Practices (RSP) handbook identifies opioid stewardship as a strategic priority and mandates that institutions implement an opioid stewardship program to enhance the safe and appropriate use of opioids.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

**Change Ideas**

Change Idea #1 Develop an opioid stewardship policy and procedure in alignment with Accreditation Canada Standards by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the project at the Safe Medication Practices Committee	Number of published policies.	Publish one policy on opioid stewardship.	

Change Idea #2 Select key performance indicators for future reporting and tracking purposes by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the project at the Safe Medication Practices Committee	Number of approved KPIs.	Approve 1 set of KPIs for reporting and tracking.	

Change Idea #3 Assess baseline knowledge of best practices for opioid prescription and administration to determine educational gaps for physicians and nursing by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the project at the Safe Medication Practices Committee	Number of completed assessments of staff and physician knowledge.	1 complete assessment of staff and physician knowledge.	

Change Idea #4 Engage with patient partners to develop an educational resource on safe opioid use. by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the project at the Safe Medication Practices Committee	Number of educational resources for patients on safe opioid use.	1 educational resources for patients on safe opioid use.	

**Measure - Dimension: Safe**

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Noise Level Awareness	C	Units / All inpatients	In house data collection / 2026-2027	1.00	2.00	Increase awareness of barriers to rest and sleep.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 The project team will expand the Noise Reduction pilot to H3 and H5 by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of units incorporated into Noise Reduction project.	Two inpatient units incorporated into Noise Reduction Project.	

Change Idea #2 The project team will complete a patient survey related to noise and disruption on H3 and H5 patients by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of patient surveys completed.	2 patient surveys related to noise and disruption completed.	

**Measure - Dimension: Safe**

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improving Compliance with Transfer of Accountability Practices During Inpatient Unit Transfers at UOHI	C	Transfers / All patients	EMR/Chart Review / 2026-2027	CB	CB	Inconsistent or incomplete handovers can lead to communication breakdowns, adverse events, and reduce quality of care.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

Change Idea #1 Assess current compliance with TOA practices among nurses during inpatient unit transfers by September 2026.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of completed assessments of current performance.	1 completed assessments of current performance.	

Change Idea #2 Improve EPIC TOA Template based on assessment.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of improved Epic TOA templates.	1 improved Epic TOA templates.	

Change Idea #3 Monitor compliance post-implementation of new EPIC TOA template.

Methods	Process measures	Target for process measure	Comments
Monitoring of the Quality Improvement Plan	Number of reports for compliance shared post-implementation of new EPIC TOA template.	1 report for compliance.	

### Measure - Dimension: Safe

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
IPAC Audits	C	Number / Audits	In house data collection / 2026-2027	CB	CB	A standardized tool is essential to ensure reliability of audits, enhance leadership involvement, and meet Accreditation Canada IPAC expectations. Completing the tool and piloting it in the in-patients areas during this QIP cycle will lay the foundation for organization-wide adoption and future compliance monitoring.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

### Change Ideas

Change Idea #1 Create a clear, user-friendly auditing format and checklist aligned with Accreditation, IPAC best practices, and UOHI workflows by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> <li>Benchmark existing IPAC tools and best practices.</li> <li>Co-design audit checklist and workflow with IPAC and clinical leaders.</li> <li>Build digital or form-based audit tool (e.g., MS Forms, Heart Survey, etc.).</li> </ul>	# of audit tool designed	1 audit tool designed	

Change Idea #2 Engage Leaders in Audit Process including regular audit scheduling, and structured feedback loops by March 31, 2027.

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> <li>Implement audits in all in-patients units (RRC, H3, H4, H5)</li> <li>Refine based on findings and prepare for broader adoption.</li> </ul>	<ul style="list-style-type: none"> <li>% of scheduled audits completed with leaders</li> <li>% Audit results shared</li> </ul>	<ul style="list-style-type: none"> <li>90 %of scheduled audits completed with leaders</li> <li>90 % Audit results shared</li> </ul>	

**Measure - Dimension: Safe**

Indicator #17	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication Audits	C	Number / Audits and Audit Tools	In house data collection / 2026-2027	4.00	4.00	<ul style="list-style-type: none"> <li>• The Quality and Pharmacy Departments would like to continue audits to quarterly to ensure compliance with Accreditation Standards.</li> <li>• The Quality and Pharmacy Departments would like to audit the COR, Cath and EP Labs to ensure compliance with Accreditation Standards.</li> </ul>	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

**Change Ideas**

**Change Idea #1** To ensure compliance with Medication Safety Accreditation Standards, the Quality and Pharmacy Departments will continue to conduct quarterly Safe Medication Practices Audits on each unit for fiscal year 2026-27.

Methods	Process measures	Target for process measure	Comments
Results reported to participating clinical units quarterly.	<ul style="list-style-type: none"> <li>• Quarterly audits completed.</li> <li>• Reports posted on Quality Boards.</li> </ul>	<ul style="list-style-type: none"> <li>• 4 Audits completed each quarter.</li> </ul>	<ul style="list-style-type: none"> <li>• Results report to posted on each unit audited.</li> </ul>

Change Idea #2 The team would also like to expand audits to include COR, Cath/EP and ACTU to ensure compliance is monitored in these areas.

Methods	Process measures	Target for process measure	Comments
New audit templates for COR, EP/Cath Labs piloted quarterly.	New audit templates approved for each of COR, EP/Cath Labs.	2 new audit templates piloted and approved for ongoing use in quarterly audits.	