Thunder Bay Regional Health Sciences Centre

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Summary Status Response to the Auditor General of Ontario Report

September 15, 2020

Auditor's Recommendation	Completed Undertaking
Recommendation 1 To further emphasize patient safety as a foundation for hospitals' organizational culture, we recommend that hospitals explicitly incorporate the words "patient safety" in their mission, vision, and/or as one of their core values, and communicate this to their staff, ensuring that related actions demonstrate this emphasis.	Our Hospital's draft new Mission and Values include "Quality", which encompasses safety (STEEEP for Safe, Timely, Effective, Efficient, Equitable, and Patient and Family Centred)
Recommendation 2 To determine and reduce the impact of never-events on patient safety and the health-care system, we recommend that the Ministry of Health (MOH): • develop a system to accumulate and track hospital never-event data; • analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and • Partner with hospitals to develop a plan to prevent them from happening.	Our Hospital has added Never Events to its Quality Improvement Plan (QIP) for monitoring and reporting, with a target of zero Never Events. • done through our QIP; • QIP data reported to the MOH.
Recommendation 3 To minimize the occurrence of serious preventable patient safety incidents, we recommend that hospitals: • enhance patient safety practices to eliminate the occurrence of never-events;	• Should a never event occur, it is reviewed by an inter-professional team of health care professionals; the review recommendations are

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	shared with the appropriate departments or clinical programs for follow-up action. All critical incidents, including never events, are addressed through formalized processes, with oversight by our internal Quality of Care Committee and strategic alignment with the Patient Safety and Quality of Care Committee of the Board of Directors. Never events will be reported internally through the same process as critical incidents. Continuous quality improvement initiatives are ongoing to prevent these events from taking place
• set a formal target to eliminate the occurrence of never-events and include this target in their quality improvement plans; and	• We agree with this recommendation.
• track and report never-events to the Ministry of Health.	• Annually an update on progress for the QIP is provided to Health Quality Ontario; using this medium could be a summary report of never events to the MOH.
Recommendation 4 To better enable hospitals to prevent similar patient safety incidents, including never-events, from recurring at different hospitals, we recommend that the Ministry of Health work with the Ontario Hospital Association (OHA) to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.	We look forward to collaborating with both the MOH and the OHA to participate in knowledge transfer activities with other hospitals.
Recommendation 5 To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, we recommend that the Ministry of Health have	We will support the OHA and CNO to identify and address gaps.

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the Ontario Hospital Association work with the College of Nurses of Ontario (CNO) and other regulatory stakeholders in order to: • identify gaps with the current information available to prospective employers regarding past performance issues and terminations; and • take steps to address any gaps identified.	
Recommendation 6 In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, we recommend that hospitals: • use the National Council of State Boards of Nursing public database to determine if nurses they hire and employ have faced disciplinary actions in the United States; • if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database; and • work with the Ontario Hospital Association to establish an internal database where terminations of employee nurses and banning of agency nurses can be accessed and cross-referenced among hospital members.	• We support this recommendation for nurses coming or having worked in the United States; these individuals however only represent a small fraction of the nursing workforce. • For the record, our Hospital does not employ agency nurses as a matter of principle. • We will definitely engage with the OHA, member hospitals and the CNO to enhance the information that is available to employers regarding past employment and disciplinary history upon hiring Nurses. Our current practice is to check employment references and the CNO registry (or other provincial colleges as applicable) prior to hiring a Nurse. The CNO registry does provide the most recent information about disciplinary history.
Recommendation 7	

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To help ensure that when hospitals hire nurses they have access to their full disciplinary record, we recommend that the Ministry of Health request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to: • explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and • put in place an effective process that will ensure that all places of past employment and disciplinary records from other jurisdictions for each nurse are in its database, including records from U.S. nursing databases.	We agree that this is a sound recommendation. We will gladly support and collaborate with the MOH, the OHA, and the CNO to enhance the information that is available to employers regarding past employment and disciplinary history upon hiring out of province Nurses.
Recommendation 9 In the interest of patient safety and in order for hospitals and agencies to hire nurses fully aware of their past employment and performance history, we recommend that the Ministry of Health explore means to: • enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and • require these organizations to disclose such information when it is requested by a prospective employer.	We agree that this is a sound recommendation. We will cooperate with the MOH to enhance the information that is available to employers regarding past employment and performance history upon hiring Nurses.
Recommendation 10 To help ensure hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to:	

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• perform criminal record checks before hiring nurses and other health-care employees; and • periodically update checks for existing staff, especially those who work with children and vulnerable patients.	• A Satisfactory Criminal Record Check is a mandatory condition of employment for all Hospital staff. Employees caring for vulnerable patient populations are required to provide a Vulnerable Sector Check. This has been in place since 2015. • Effective March 31, 2020, an annual Criminal Record or Vulnerable Record check, as the case may be, self-disclosure is mandatory for all paid employees. The Ontario Nurses Association and Service Employees International Union (representing service and Registered Practical Nurses) have grieved this new policy. Legislation would be beneficial to ensure that we can enforce this policy.
Recommendation 11 To enable hospitals to take timely action to maximize patient safety, we recommend that the Ministry of Health explore means to make it easier and less costly for hospitals and ultimately the taxpayer to discipline doctors who harm patients.	We will actively cooperate with the MOH to explore how to implement this recommendation.
Recommendation 12 To improve patient safety, we recommend that the Ministry of Health: • review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high- priority criteria; and	• Accreditation Canada reports belong to the hospitals they survey; hospitals are not expected to share their survey reports with the MOH, especially in as much as being accredited is not provincially mandated in Ontario. However, the Royal College of Physicians and Surgeons requires hospitals accepting learners to be accredited.

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• follow up with hospitals in respect of problem areas to ensure that actions are taken in order to correct deficiencies.	• Accreditation Canada has a very stringent process to review survey recommendations, especially unmet Required Organizational Practices (ROP) that, if consistently unmet, can lead to suspended or no accreditation. As a matter of information, some provinces have now made it mandatory to be accredited by a recognized accrediting body (Accreditation Canada, Commission on Accreditation of Rehabilitation Facilities, etc).
Recommendation 13 To help ensure that hospitals have all the necessary patient information to properly investigate any incidents with patients' dosages or drug interactions that might occur and trigger hospital readmission, we recommend that hospitals establish effective medication reconciliation documentation processes so that all the necessary information is always documented.	This is actually one of Accreditation Canada's ROPs. Our Hospital has actually engaged in the last 2 years in extending this practice to all inpatient programs by securing funding for dedicated Pharmacy Technicians Medication Reconciliation to formally document patient medications on admission. This province, especially in remote areas, is facing a severe shortage of Pharmacy Technicians which has delayed the implementation of this practice.
Recommendation 14 To reduce the risk of medication errors and readmissions to hospital, we recommend that the Ministry of Health: • require hospitals to complete medication reconciliation for all patients; • require all hospitals to report their compliance information to Health Quality Ontario; and • in conjunction with relevant hospitals, review their IT system needs to be able to	• We agree to cooperate with the MOH on implementing this recommendation, including how to expand education opportunities to train and graduate more Pharmacy Technicians to meet system needs. • We agree to cooperate with HQO at implementing this recommendation. • In conjunction with St. Joseph's Care Group, our IT/IS partner, we are developing a process for the

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track the information and action improvement where needed.	mandatory reporting of severe adverse drug reactions.
Recommendation 15 To improve patient safety, we recommend that hospitals reinforce with nurses necessary processes to ensure that: • independent double-checks are done to verify that correct medication and dosage are administered; • nurses witness patients taking and swallowing high-risk medications; and • nurses confirm the identities of patients before administering medication to them.	• Independent double-checks are systematically carried on to verify that correct medication and dosage are administered. Furthermore, our hospital policy requires that Nurses perform an independent double check for specific high alert medications in all programs. Nursing Practice Leaders also review all reported medication errors and complete follow-ups and education as deemed necessary. • Nurses must witness patients taking and swallowing medications, especially high-risk medications. Our policy states that the individual preparing the medication must administer it to the patient and observe the patient taking the medication or remain with the patient until all medications have been taken. • Nurses must confirm the identity of patients before administering their medications. Our policy applies the six rights of medication administration: 1) The right patient; 2) The right medication; 3) The right dose;

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	4) The right method (route) of administration; 5) The right time; 6) The right chart/record for documentation.
Recommendation 16 To minimize patient safety incidents due to missing information or miscommunication, we recommend hospitals adopt, based on patient condition, the practice of making nursing shift changes at the patients' bedside and where possible involving the patients and their families, with the consent of the patients, in the process.	Our Nurses complete a Shift Summary note prior to end of shift. The note is then reviewed by the oncoming staff. The Shift Summary provides comprehensive, updated information regarding a patient's status. Additionally we use the SBAR (Situation, Background Assessment, and Recommendation) tool that is completed when a patient moves between units. This information is part of the patient chart.
Recommendation 17 To maximize patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, we recommend that the Ministry work with hospitals toward the automation of pharmacy-related tasks.	The hospital is installing automated dispensing cabinets on all inpatient units. We are currently implementing initiatives to increase automation of pharmacy-related tasks. We will gladly cooperate with the MOH to consider further automation where cost effective measures exist.
Recommendation 18 To improve the accuracy of reported hand hygiene compliance, we recommend that the Ontario Hospital Association work with hospitals to further the adoption of additional methods to assess and monitor hand hygiene, such as electronically monitored hand hygiene pumps and monitoring systems, and asking patients to observe and record the hand	We implemented a new electronic system to collect the hand hygiene auditing data. It is easier to use and collect meaningful data. We are now exploring a new auditing model to determine who performs the audits using this new system. Historically, managers and IPAC staff conducted the audits but we have observed data that are more valid when other individuals perform the audits. We are looking at leaders who are unknown to the unit staff and volunteers to conduct the audits.

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hygiene compliance of their health-care providers.	
Recommendation 19 To help ensure that sterile-rooms and equipment used in the mixing and preparation of intravenous medication are cleaned according to required standards, we recommend that hospitals: • provide their pharmacy and housekeeping staff with proper training on how to conduct the cleaning; and • monitor the cleaning to ensure proper processes are being followed.	We agree with the recommendation and have taken the following initiatives to comply: • We are making progress towards full Ontario College of Pharmacists compliance with people and processes standards for NAPRA sterile compounding; • Our Clinical and Compounding Coordinator ensures staff are certified annually to perform sterile compounding. As well, a Quality Assurance program ensures all processes are followed according to standards. The QA program involves auditing our staff and the processes involved in sterile compounding.
Recommendation 20 To improve hospitals' compliance with the Canadian Standards Association's (CSA) standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals establish an action plan to have their washing and sterilization of surgical tools and medical equipment inspected on a regular basis.	We agree with this recommendation. Indeed, we test reprocessed equipment at the start of each day for any protein residue. Also, we continuously review other inspection processes for implementation, in discussion with other hospitals and the CSA.
Recommendation 21 To help ensure that contracts with private providers of sterilization services are managed	We do not have contracts with private providers of sterilization services.

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effectively by hospitals, we recommend that hospitals: • include all the necessary service standards and key performance indicators in these contracts; and • on a regular basis, assess the private service provider's compliance with all contract terms.	
Recommendation 22 To ensure that patients with a life or limb threatening condition receive timely care from the closest hospital, we recommend the Ministry of Health leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.	We are a test site for the new bed command center.