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ACUTE-CARE HOSPITAL PATIENT SAFETY AND DRUG ADMINISTRATION (SEC. 3.01, 2019 ANNUAL REPORT OF THE AUDITOR GENERAL OF ONTARIO) BACKGROUND MATERIAL FOR HEARINGS *

Prepared for:

Standing Committee on Public Accounts

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PREAMBLE

This research package has been prepared by the Legislative Research Service with input from the Office of the Auditor General (the Auditor). It provides a brief summary and relevant documents for the Committee's hearings on Sec. 3.01 "Acute-Care Hospital Patient Safety and Drug Administration" of the Auditor General's *2019 Annual Report.*

Note: Please refer to the audit itself (see Appendix item 1) when quoting the Auditor during hearings rather than to research background material or the Auditor's PowerPoint briefing (these are confidential Committee documents).

OVERVIEW

Patient safety refers to reducing the risk of unintentional patient harm through policies and procedures that hospitals design, implement and follow. Patient safety incidents—such as hospital-acquired infections and medication errors—can be caused by poorly-designed systems and processes, and unsafe human acts in the delivery of hospital care.[1]

The Auditor found that while most patients in Ontario's acute-care hospitals never suffer harm during treatment, more could be done to improve patient safety. Data shows that of more than one million patients discharged annually from Ontario's acute-care hospitals, approximately 67,000 were harmed during their hospital stays.[2] Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital.[3] The audit found that while hospitals have effective processes in place to investigate and learn from patient-safety incidents, the Ministry of Health and hospitals were not doing all they could to further minimize patient harm.

Under the *Public Hospitals Act, 1990* and the *Excellent Care for All Act, 2010*, hospitals must establish governance and reporting structures to monitor and address patient safety concerns.[4]

Hospitals follow patient safety standards and best practices developed by several different federal, provincial and not-for-profit organizations. Some standards and best practices pertain to specific areas of care, such as surgery, or to specific departments within the hospital, such as the hospital pharmacy. Other standards pertain to the hospital as a whole, such as infection prevention and control.[5] There are also legislated requirements that apply to the hospital as a whole.

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[1] "Acute-Care Hospital Patient Safety and Drug Administration," Auditor General's *2019 Annual Report*, Sec. 3.01, p. 67.
[2] AG Report, p. 67. The Auditor notes that "this is the second-highest rate of hospital patient harm in Canada, after Nova Scotia."
[3] AG Report, p. 67, p. 72ff.
[4] AG Report, p. 73.
[5] AG Report, p. 75.

This audit focused on patient safety in acute-care hospitals, which primarily deliver active short-term treatment. As of April 1, 2019, there were a total of 141 public hospitals in Ontario, located across a total of 224 sites. These include 123 acute-care hospitals where patients usually receive short-term treatment; eight chronic care and rehabilitation hospitals for patients with long-term needs; four specialty psychiatric hospitals; and six hospitals that provide a variety of outpatient and rehabilitation services. The audit uses the term "hospitals" to refer only to acute-care hospitals.

Relevant Agencies and Organizations

- Accreditation Canada is a non-governmental, not-for-profit organization. Every four years the organization visits and accredits all 141 (123 acute-care) hospitals in Ontario, as well as other health-care facilities, against national standards. The visits are conducted to assess hospitals' compliance with all applicable standards and required practices in six patient safety areas.[6]
- The Canadian Institute for Health Information (CIHI) provides comparable and actionable data and information that are used to accelerate improvements in health care, health system performance and population health across Canada.
- The College of Nurses of Ontario is the self-regulating governing body for Ontario's Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Nurse Practitioners (NPs). The role of the College and its authority and powers are set out in the *Regulated Health Professions Act* (RHPA) and the *Health Professions Procedural Code* under the RHPA.
- The College of Physicians and Surgeons of Ontario (CPSO) regulates the practice of medicine in Ontario. The role of the College and its authority and powers are set out in the *Regulated Health Professions Act* (RHPA), the *Health Professions Procedural Code* under the RHPA, and the *Medicine Act.*
- CritiCall Ontario is funded by the Ministry of Health and provides a variety of services to physicians, hospitals, and other healthcare stakeholders with the goal of helping to ensure that patients can access the urgent and emergency care they need as close to home as possible.
- Ontario Health is a new provincial agency that will incorporate and coordinate the work of existing provincial health agencies and programs.
- The Ontario Hospital Association (OHA) represents Ontario's public hospitals, providing advocacy, learning and engagement, collective bargaining, and data and analytics support.

[6] AG Report, p. 75. See Appendix 4 of the AG's report for the required practices in these six patient safety areas.

2019 Audit Objective and Scope

The objective of the audit was to "assess whether acute-care hospitals achieve patient safety by

- ensuring that staff have processes in place that support the safe and appropriate use of equipment, procedures and medication in delivering medical care to patients;
- implementing effective processes and systems to identify and reduce the risk of patient harm; and
- identifying, reporting and responding to incidents of patient harm (including learning from past incidents and taking steps to prevent them from recurring)."[7]

The audit team visited acute-care hospitals of various sizes in regions across the province, as well as meeting with stakeholders and experts, and reviewing relevant documents.

Main Points of 2019 Audit

The Auditor found that "current laws and practices in Ontario make it difficult for hospitals to address concerns with the safety of care provided by some nurses and doctors."[8]

The Auditor's significant findings include:

Patient safety culture

- Patient safety culture at different hospitals varies significantly, from excellent to poor and failing. Patient safety "**never-events**" (preventable incidents that could cause serious patient harm or death) have occurred at six of the hospitals visited by the Auditor.
- At six of the 13 hospitals visited by the Auditor that track such incidents, never-events have occurred a total of 214 times since 2015. (Ontario hospitals are not required to report never-events to the Ministry of Health.)[9]
- The most recent Accreditation Canada hospital reports show that 18 hospitals did not comply with five or more required practices that are central to quality care and patient safety.[10]

[7] AG Report, p. 78.
[8] AG Report, p. 67.
[9] AG, Summary of "2019 Value-for-Money Audit of Acute-Care Hospital Patient Safety and Drug Administration."
[10] AG, Summary.

Nurses

- Current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Limited information about nurses is available to prospective employers and this restricts the employers' ability to assess past performances.
- Nurses who have been repeatedly terminated or banned by hospitals for lacking competence and/or having practice issues are rehired by other hospitals and/or agencies and continue to pose a risk to patient safety, as hospitals may not share relevant information about a nurse's employment and performance history with other potential employers.[11]

Physicians

- Hospitals are not able to quickly and cost-effectively terminate physicians whom hospitals have found lack competence and harm patients.

Medication administration

- Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is improving.
- Hospitals do not always follow best practices for medication administration.
- Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.

[11] AG, Summary.

AUDITOR GENERAL'S RECOMMENDATIONS AND POSSIBLE COMMITTEE QUESTIONS

Patient Safety Culture

The Auditor reported that patient safety culture at different hospitals varies significantly, from excellent to poor and failing. Patient safety "never-events" have occurred at six of the hospitals visited by the Auditor. Ontario hospitals are not required to report never-events to the Ministry of Health.[12]

Between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices and standards. For example, hospital staff may not be washing their hands as frequently as reported, which contributes to the spread of hospital-acquired infections among patients.

Hospital-acquired infections such as C. difficile are most commonly spread via the hands of health-care workers. The Auditor reports that patients who acquire C. difficile during their hospital stay required additional treatment costing an average of $9,000 per patient.[13]

AG 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.

Possible Committee Question

1. Have hospitals incorporated principles and language around "patient safety" in their mission, vision, and/or as one of their core values?

AG 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

- work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data;
- upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and
- partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent them from happening.

[12] AG, Summary.
[13] AG, Summary.

Possible Committee Questions

1. Has the Ministry of Health initiated work with internal and external partners to leverage existing systems that can accumulate and track hospital never-event data? If so, what type of work has been completed to date?
2. Is the Ministry now analyzing the frequency of never-events at Ontario hospitals and estimating their cost to the health-care system?
3. Has the Ministry partnered with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent never-events from happening? If so, which organizations and stakeholders? If not, have you identified which stakeholders/organizations could help you the most?

AG 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;
- set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans; and
- track and report never-events to the Ministry of Health.

Possible Committee Questions

1. What have hospitals done recently to enhance patient safety practices to eliminate the occurrence of never-events?
2. Have hospitals now set a formal target to eliminate the occurrence of never-events and included this target in their Quality Improvement Plans?
3. Which hospitals are tracking and reporting never-events to the Ministry of Health? If none, is there a plan for hospitals to start reporting the never-events to the Ministry?

AG 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 and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.

Possible Committee Question

1. Has the Ministry of Health implemented the Auditor's recommendation that it work with the Ontario Hospital Association and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations?

Nurses and Patient Safety

About 74,000 nurses work in acute-care hospitals, comprising the largest single component of hospital staff, and providing hands-on care to patients at their bedside. Most nurses are employees of the hospital. However, hospitals may also recruit additional temporary nurses from external agencies. These nurses are not employees of the hospital. (About 4,600 nurses were employed via nursing agencies in 2017. Nursing agencies are unregulated.)[14]

The Auditor reported that current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Non-disclosure arrangements negotiated with hospitals by unions, along with concerns about potential civil legal actions, can result in potential new employers not being made aware of a nurse's poor past performance. The audit found that "such practices can mislead hiring hospitals and pose an increased risk to patient safety."[15]

The Auditor notes that Canada (unlike the United States) has no centralized system to which all provincial nursing regulatory bodies can report their disciplinary actions. The Auditor recommended (see AG Recommendation 6 below) that Ontario hospitals consult a US public database.[16]

AG 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 the Ontario Hospital Association work with the College of Nurses of Ontario and other regulatory stakeholders to

- identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and
- take steps to address gaps identified.

Possible Committee Question

1. Has the Ministry of Health worked with the College of Nurses of Ontario and other regulatory stakeholders to
   a) identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and
   b) take steps to address the gaps identified?

[14] AG Report, p. 75.
[15] AG Report, p. 68.
[16] AG Report, p. 88.

AG 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 whether nurses they hire and employ have faced disciplinary actions in the United States; and
- if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.

Possible Committee Questions

1. Are hospitals using the National Council of State Boards of Nursing public database to determine whether nurses they hire and employ have faced disciplinary actions in the United States?
2. Are hospitals that use agency nurses requiring nursing agencies to confirm that these nurses have been screened through this database?

AG Recommendation 7

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 US nursing databases.

Possible Committee Question

1. Are the Ontario Hospital Association and the College of Nurses of Ontario working together with their provincial and territorial counterparts to

    a) explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and

    b) 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 US nursing databases?

AG Recommendation 8

To better inform employers in their hiring decisions and protect patients from the risk of harm, we recommend that the Ministry of Health assess for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.

Possible Committee Question

1. Has the Ministry of Health assessed for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer?

AG 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.

Possible Committee Question

1. Has the Ministry of Health explored means to enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and required these organizations to disclose such information when it is requested by a prospective employer?

AG Recommendation 10

So that hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to

- perform criminal record checks before hiring nurses and other health-care employees; and
- periodically update checks for existing staff.

Possible Committee Question

1. Is the Ministry of Health requiring all hospitals in Ontario to
    a) perform criminal record checks before hiring nurses and other health-care employees; and
    b) periodically update checks for existing staff?

Physicians and Patient Safety

There are about 37,000 physicians in Ontario. Practicing physicians must be members of the College of Physicians and Surgeons of Ontario, which regulates the practice of medicine to protect and serve the public interest.

The *Public Hospitals Act, 1990* governs important elements of the relationship between hospitals and physicians, and requires a comprehensive legal process for hospitals to resolve human resources issues with physicians. This makes it "difficult and costly for hospitals to discipline or terminate physicians whom they find to have competency and/or practice concerns. For instance, separate disciplinary proceedings against one particular physician has cost three hospitals over $1.5 million combined. In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers of Ontario" through a liability insurance program.[17]

AG Recommendation 11

To enable hospitals to take timely action to improve 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 address physician human resources issues, especially in cases when doctors may have harmed patients.

Possible Committee Question

1. Has the Ministry of Health explored means to make it easier and less costly for hospitals and ultimately the taxpayer to address physician human resources issues, especially in cases when doctors may have harmed patients?

Patient Safety Practices

The Auditor obtained the most recent Accreditation Canada report from 114 acute-care hospitals and found that between 2014 and 2019, 18 hospitals did not comply with five or more required practices that are important for quality and patient safety.[18] For example, some hospitals did not have strategies in place to help prevent patient falls and pressure injuries; some hospitals did not fully meet a significant number of high-priority criteria for infection prevention.[19] Accreditation Canada found the highest rate of patient safety concerns with medication management and emergency services.

[17] AG, Summary and AG Report, p. 92.
[18] AG Report, p. 94.
[19] AG Report, p. 94, p. 69.

AG 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
- follow up with hospitals in respect of problem areas to confirm that actions are taken to correct deficiencies.

Possible Committee Question

1. Has the Ministry of Health
   a) reviewed the Accreditation Canada hospital reports to identify areas where hospitals may not be consistently meeting required patient safety practices and high-priority criteria; and
   b) followed up with hospitals in respect to problem areas to confirm that actions are taken to correct deficiencies?

Medication Administration

The Auditor reported that:

- Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is improving.
- Hospitals do not always follow best practices for medication administration.
- Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.

AG Recommendation 13

So that hospitals fully complete medication reconciliation to reduce the risk to discharged patients and that they 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 reinforce with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented.

Possible Committee Question

1. How are hospitals reinforcing with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented?

AG 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 hospitals to include medication reconciliation in their Quality Improvement Plans; and
- in conjunction with relevant hospitals, review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed.

Possible Committee Question

1. Is the Ministry of Health
   a) requiring hospitals to complete medication reconciliation for all patients;
   b) requiring hospitals to include medication reconciliation in their Quality Improvement Plans; and
   c) in conjunction with relevant hospitals, reviewing hospital information technology (IT) system needs to be able to track necessary medication reconciliation information and take action for improvement where needed?

AG Recommendation 15

To improve patient safety, we recommend that hospitals reinforce with nurses necessary medication administration processes to ensure that

- independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered;
- nurses witness patients taking and swallowing high-risk medications; and
- nurses use two unique identifiers to confirm the identity of patients before administering medication to them.

Possible Committee Question

1. How are hospitals reinforcing with nurses necessary medication administration processes to ensure that
   a) independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered;
   b) nurses witness patients taking and swallowing high-risk medications; and
   c) nurses use two unique identifiers to confirm the identity of patients before administering medication to them?

AG 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.

Possible Committee Question

1. Have hospitals adopted (based on patient condition) the practice of making nursing shift changes at patients' bedsides and where possible involving the patients and their families (with the consent of the patients) in the process?

AG Recommendation 17

To improve 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.

Possible Committee Question

1. How is the Ministry working with hospitals toward the automation of pharmacy-related tasks?

Infection Prevention

The Auditor reported that between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices and standards. For example,

- hospital staff may not be washing their hands as frequently as reported, which contributes to the spread of hospital-acquired infections among patients;
- some hospital pharmacies did not fully comply with training and cleaning standards for sterile-rooms (where intravenous medications are prepared and mixed); [20]
- hospital pharmacies also do not always fully comply with standards pertaining to the sterile preparation and mixing of hazardous (chemotherapy) and non-hazardous intravenous medications;[21] and
- the inspection process for cleaning reusable surgical tools is not optimal (improper cleaning of reusable surgical tools can delay surgeries and impact patients).

The Auditor noted that there are significant additional costs to the provincial health care system to treat patients for hospital-acquired infections.[22]

[20] AG Report, p. 103.
[21] AG Report, p. 104.

AG Recommendation 18

To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, we recommend that the Ontario Hospital Association work with hospitals to evaluate and 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 hygiene compliance of their health-care providers.

Possible Committee Question

1. Has the Ontario Hospital Association worked with hospitals to evaluate and adopt 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 hygiene compliance of their health-care providers?

AG Recommendation 19

So that sterile-rooms and the equipment used in the mixing and preparation of intravenous medications 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.

Possible Committee Question

1. Are hospitals

    a) providing their pharmacy and housekeeping staff with proper training on how to conduct cleaning according to required standards; and

    b) monitoring the cleaning to ensure proper processes are being followed?

AG Recommendation 20

To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.

Possible Committee Question

1. Are hospitals ensuring that there are regular inspections of their processes for washing and sterilization of surgical tools and medical equipment?

[22] AG Report, p. 102.

AG Recommendation 21

In order for contracts with private providers of sterilization services to be managed effectively by hospitals, we recommend that hospitals

- include all the necessary service standards and performance indicators in these contracts; and
- on a regular basis, assess the private service provider's compliance with all contract terms.

Possible Committee Question

1. Are hospitals
   a) including all the necessary service standards and performance indicators in contracts with private providers of sterilization services; and
   b) regularly assessing the private service providers' compliance with all contract terms?

Hospital Overcrowding

The Auditor noted that critically-ill patients depend on receiving timely and appropriate care. However, according to CritiCall (a Ministry-funded 24-hour emergency referral service used by physicians dealing with critically ill patients), from April 2016 to the end of March 2019, 784 critically-ill patients were denied inter-facility transfer to the closest hospital that could provide the appropriate level of care because the hospital had no bed available to receive the patient.[23]

In recent years, some hospitals, such as Humber River Hospital, have created hospital-based command centres that manage beds more efficiently and thereby reducing patient wait times for hospital beds.[24] In August 2019, CritiCall proposed the creation of a province-wide "command centre" initiative that would collect and analyze, in real time, the patient bed flow of each acute-care hospital in Ontario.

AG Recommendation 22

So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, we recommend that 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.

Possible Committee Question

1. How has the Ministry of Health leveraged lessons learned from hospital-based "command centres" and worked with CritiCall toward the development of a provincial bed command centre?

[23] AG Report, p. 107.
[24] AG Report, p. 108.

APPENDICES

1. "Acute-Care Hospital Patient Safety and Drug Administration," Auditor General's *2019 Annual Report*, Sec. 3.01.

2. Auditor General, Summary of "2019 Value-for-Money Audit of Acute-Care Hospital Patient Safety and Drug Administration."

3. Status Update, Ministry of Health, May 19, 2021.

4. Status Update, Ontario Hospital Association, May 20, 2021.

5. Status Update, Thunder Bay Regional Health Sciences Centre, September 15, 2020.