Chapter 3
Section
3.03

Ministry of Health and Long-Term Care

Large Community Hospital Operations

Standing Committee on Public Accounts Follow-Up on Section 3.08, *2016 Annual Report*

In April 2017, the Standing Committee on Public Accounts (Committee) held a public hearing on our 2016 audit of Large Community Hospital Operations. The Committee tabled a report in the Legislature resulting from this hearing in February 2018. The report can be found at **www.auditor.on.ca/en/content/standingcommittee/standingcommittee.html**.

The Committee made 16 recommendations and asked the Ministry of Health and Long-Term Care (Ministry) and hospitals to report back by June 22, 2018. However, at the time of our follow-up, the Legislative Assembly was dissolved following the provincial election on June 7, 2018. As such, the Committee did not have a membership to accept the responses from the Ministry and hospitals until properly reconstituted after the resumption of the House. The Ministry and hospitals formally responded to the Committee on July 29, 2018. A number of issues raised by the Committee were similar to the observations in our 2016 audit. The status of each of the Committee's recommendations is shown in **Figure 1**.

We conducted assurance work between April 1, 2018, and August 3, 2018, and obtained written representation from the Ministry and hospitals that, effective October 31, 2018, they have provided us with a complete update of the status of the recommendations made by the Committee.

Overall Conclusion

As of August 3, 2018, 73% of the Committee's recommendations have been fully implemented, a further 21% of the recommendations were in the process of being implemented, and the remaining 6% of recommendations had little or no progress.

Important Event Following Our 2016 Audit

Amalgamation of Hospitals

Our 2016 audit focused on three large community hospitals: Trillium Health Partners (Trillium), Windsor Regional Hospital (Windsor), and Rouge Valley Health System (Rouge).

Subsequent to our audit, two sites of Rouge (Centenary site and Ajax/Pickering site) have merged with two other hospitals in response to the recommendations by the Scarborough/West Durham Expert Panel, which reviewed and reported back to the Ministry on how to improve integration and access to acute health care-services. Effective December 1, 2016, Rouge's Centenary site has merged with The Scarborough Hospital to create Scarborough and Rouge Hospital, and Rouge's Ajax/Pickering site has merged with Lakeridge Health.

To ensure completeness of our follow-up work, we assessed the status of actions taken by Rouge based on information provided by both Scarborough and Rouge Hospital (former Rouge's Centenary site) and Lakeridge Health (former Rouge's Ajax/Pickering site).

Detailed Status of Recommendations

Figure 2 shows the recommendations and the status details that are based on responses from the Ministry, and our review of the information provided.

Figure 1: Summary Status of Actions Recommended in February 2018 Committee Report
Prepared by the Office of the Auditor General of Ontario

		Status of Actions Recommended				
	# of Actions Recommended	Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	1	1				
Recommendation 2	4	4				
Recommendation 3	3	1 1/3	1 2/3			
Recommendation 4	2	2				
Recommendation 5	1	1/3	2/3			
Recommendation 6	3	2	1			
Recommendation 7	1		1			
Recommendation 8	1		1			
Recommendation 9	1	1				
Recommendation 10	2	2				
Recommendation 11	3	2 1/3	2/3			
Recommendation 12	1			1		
Recommendation 13	1			1		
Recommendation 14	2	2				
Recommendation 15	5	4	1			
Recommendation 16	3	3				
Total	**34**	**25**	**7**	**2**	**0**	**0**
%	**100**	**73**	**21**	**6**	**0**	**0**

Figure 2: Committee Recommendations and Detailed Status of Actions Taken

Prepared by the Office of the Auditor General of Ontario

Committee Recommendation	Status Details
Recommendation 1 The Ministry of Health and Long-Term Care should plan appropriately to ensure that funding to hospitals is timely in order to enable cost effective and efficient operations, and enable hospitals to deliver surgeries when needed. **Status: Fully implemented.**	During our follow-up, we noted that the Ministry had distributed its funding allocations to hospitals early in the fiscal year. The Ministry had also established processes for the hospitals and Local Health Integration Networks (LHINs) to review their current funding and correct any data-quality issues before potential investments are made. In addition, the Ministry has updated the Quality-Based Procedures Volume Management Instructions, which outline the policies under the Ministry's Health System Funding Reform. These instructions provide direction regarding in-year reallocations, and year-end reconciliations and processes for the 2017/18 fiscal year so that LHINs can be flexible in responding to patient needs when managing services in their communities.
Recommendation 2 Ontario hospitals should better ensure timely transfer of patients from the emergency room to an acute-care bed when needed by:	During our follow-up, we noted the following actions taken by the hospitals:
• monitoring the bed-wait time by acute-care wards on an ongoing (e.g., hourly) basis daily; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has set up a Capacity Management Dashboard to monitor the length of stay in real-time for all admitted patients in the emergency department. **Windsor**: It has implemented a new bed-allocation model for the Medicine Program as of October 2017 to move patients from the emergency department to the relevant ward quickly. The new model uses a software program to display information such as the number of patients in the emergency department that are waiting for a bed, the length of time patients have been waiting, and a bed-readiness status code of green (less than 30 minutes), yellow (31 to 60 minutes) or red (over 60 minutes). **Rouge**: It has implemented a Daily Access Reporting Tool to provide wait-time data. It has also set up a Patient Flow Team to monitor bed-wait time and ensure timely transfer of patients from the emergency department to an in-patient bed.
• investigating significant delays; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has put Admission Co-ordinators or Patient Care Co-ordinators in place to regularly review all admitted patients who waited in the emergency department longer than the target wait time. It also monitored bed-assignment and patient-in-bed times and contacted specific units when significant delays were identified. **Windsor**: When significant delays occurred, the hospital's Program Director and Command Centre Director reviewed patient charts and provided feedback to the appropriate units. These investigations and recommendations to address delays were discussed with the Patient Flow Team during its weekly meetings. **Rouge**: It has put an Operations Supervisor and a Bed-Allocation Team in place to oversee patient flow in real time and investigate any issues and delays. It has also updated its system for prioritizing patient transport and cleaning processes to prevent significant delays.

Committee Recommendation	Status Details
• developing a crisis response system to better handle difficult cases and periods of high volume; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has completed the Capacity Management Processes and Practices framework, which provides guidance for responding to different levels of capacity, raises awareness of patient flow practices across the hospital, and sets expectations in response to patient flow challenges. It has also set up an Overcapacity Leadership Team to improve patient flow. As well, it has implemented a Capacity Management Policy and Procedure, in effect since March 31, 2017, to outline the roles, accountabilities and corporate response to overcapacity. **Windsor**: It has developed a surge plan for overcapacity situations, including opening beds at each site for which it receives no funding from the Ministry. **Rouge**: It has implemented a patient surge policy that is activated when there are more than 10 admitted patients waiting in the emergency department for in-patient beds. It has also set up a centralized staffing system with access to a nursing resource pool to assist with staffing during surge demands.
• taking corrective actions as necessary. **Status: All three hospitals: Fully implemented.**	**Trillium**: It has set up an Emergency Operations Centre to manage ongoing capacity pressures and challenges. It has also begun circulating the Capacity and Workforce Management Bi-Weekly Status Report to all clinical vice presidents and members of its Capacity Management and Workforce Planning Taskforce. The status report identifies overcapacity issues and outlines recommendations to improve patient flow by using the Capacity Management Processes and Practices framework. In addition, it established a Surge Planning Task Force to develop a plan for managing the challenges and pressures during the winter holiday period. **Windsor**: It has begun holding daily meetings at every medical or surgical unit, with social workers, nurses and other care providers to identify any issues that need to be escalated to the appropriate departments or senior management. It has also updated care and discharge plans daily to improve patient flow. **Rouge**: It has put a Patient Flow Team in place to ensure timely transfer of patients from the emergency department to an in-patient bed while giving priority to intensive-care unit patients and patients who require urgent surgeries. In April 2017, it also set up a Medical Short Stay Unit for patients expected to be discharged within 48 hours. It was also diverting patients to outpatient clinics (such as fracture clinics) as much as possible.
Recommendation 3 Hospitals should ensure the equitable and timely treatment of patients requiring emergency surgery by:	During our follow-up, we noted the following actions taken by the hospitals:
• regularly tracking, assessing, and reporting on the timeliness of emergency surgeries performed; **Status:** **Trillium Health Partners: Fully implemented.** **Windsor Regional Hospital: In the process of being implemented by April 2020.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: In May 2017, it implemented a tracking tool and guidelines to provide a standardized approach for documenting emergency surgeries. It has also established a committee on perioperative care (care that is given before and after surgery) to monitor and report the information collected by this tool. **Windsor**: Since October 2017, it has reviewed the non-scheduled surgical list daily to prioritize and develop an action plan for emergency surgeries. In April 2018, it initiated further work to confirm the criteria for placing patients on the non-scheduled surgical list and develop an electronic system to track and assess the timeliness of emergency surgeries. It expects to complete this work by April 2020. **Rouge**: In March 2017, it performed an audit to track and assess the timeliness of emergency surgeries. The audit showed that all cases of orthopedic, gynecologic, and plastic and reconstructive surgeries were performed within the targeted time.

Committee Recommendation	Status Details
• documenting, analyzing, and reporting on the reasons for delays in performing emergency surgery; **Status:** **Trillium Health Partners: In the process of being implemented by the end of December 2018.** **Windsor Regional Hospital: In the process of being implemented by April 2020.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: In 2017/18, it initiated a project to develop an audit and analysis process regarding delays in performing emergency surgeries. The project is expected to be completed by the end of December 2018. **Windsor**: It was in the process of analyzing delays with the Chief of Anesthesia and the operating room leadership team. In April 2018, it began developing an electronic system to document the reasons for delays in performing emergency surgeries. It expects to complete this work by April 2020. **Rouge**: It has analyzed and identified the top two reasons for delays in emergency surgeries: limited dedicated operating-room time and patient-related factors (for example, a patient needs to receive medication first to be medically stable for the surgery, or a patient is taking blood thinner medication and needs to stop for a few hours before surgery).
• evaluating whether to dedicate operating-room time for emergency surgeries, and/or take other measures (such as ensuring surgeons who are on call perform only emergency surgeries, as part of their regular planned activity) to reduce the risk that emergency surgery delays result in negative impacts on patient health. **Status:** **Trillium Health Partners: In the process of being implemented by the end of November 2018.** **Windsor Regional Hospital: In the process of being implemented by the end of March 2019.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: Its Divisions of Orthopedic Surgery and General Surgery have dedicated weekday operating-room blocks for emergency surgeries related to trauma cases and acute care. It has also engaged an external expert to perform a surgical platform optimization review, which includes analyzing opportunities related to emergency care. The review is expected to be completed in November 2018. **Windsor**: Its Department of Orthopedic Service has dedicated 90 minutes each day to complete non-scheduled emergency surgeries. However, it indicated that significantly more action is still needed to address this recommendation as it is still in the early stages of reviewing wait times for patients requiring emergency surgery. It also informed us that a surgical leadership team, including chiefs and physician leaders of the surgical program, were reviewing two to four years of data to determine the number of surgical beds and operating rooms required for non-scheduled and scheduled emergency surgeries. It expects to dedicate operating-room times for emergency surgeries or take other measures by the end of March 2019. **Rouge**: In May 2017, it started dedicating operating-room time for emergency surgeries. It has also implemented policies for scheduling and booking emergency surgeries, outlining a detailed process for emergency cases that need to be completed during business hours, after-hours and on weekends. These policies allow for bumping into the first available room depending on the urgency of the emergency surgery.

Committee Recommendation	Status Details
Recommendation 4 The Ministry of Health and Long-Term Care should ensure that patients get urgent elective surgery on a timely basis by:	
• reviewing the relationship between the level of funding provided for urgent elective surgeries, the wait-time targets for those surgeries, and the difficulties hospitals are facing achieving those targets within the level of funding provided; **Status: Fully implemented.**	The Ministry has established processes to engage the LHINs in reviewing wait-time data for key surgical procedures. For example, it established the Orthopaedic Quality Scorecard in 2017 to track and monitor, on a quarterly basis, performance results related to hip and knee replacement surgeries. The Scorecard includes indicators such as average acute length of stay (days) and joint replacement wait time (days), and provides information for the Ministry and LHINs to review the relationship between funding levels and wait times for this type of urgent elective surgery. In much the same way, the Foot and Ankle Dashboard, also established in 2017, tracks performance metrics relating to foot and ankle procedures. The Ministry also reviewed the Cataract Capacity Plan, submitted by the Provincial Vision Task Force (PVTF) in November 2017, to examine the factors, such as funding level, that affect the supply of cataract surgery services and their relationship with wait times. To achieve wait-time targets, the Ministry plans to use the recommendations from the PVFT's Cataract Capacity Plan for future funding decisions with a goal of achieving wait-time targets.
• using the information from this review to determine future needs for urgent elective surgery so that the risk to patients is addressed and hospitals are able to achieve the Ministry's wait-time targets for urgent elective surgery. **Status: Fully implemented.**	The Ministry has used information from the reports mentioned above, such as the Orthopaedic Quality Scorecard and the Cataract Capacity Plan, to determine funding needs and achieve wait-time targets. For example, in December 2017, the Ministry made an additional investment to fund over 160 more hip and knee replacements across the LHINs with the greatest wait-time performance challenges. As mentioned above, the Ministry plans to make future funding decisions for cataract surgery based on recommendations from the Cataract Capacity Plan to target areas of the province with higher needs. The Ministry also plans to continue to work with LHINs to identify hospitals with wait-time challenges and find potential solutions.
Recommendation 5 Hospitals should consult with the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs) when necessary to ensure that patients get urgent elective surgeries within wait-time targets by working with surgeons to identify ways to alleviate backlogs. **Status:** **Trillium Health Partners: In the process of being implemented by the end of March 2021.** **Windsor Regional Hospital: In the process of being implemented by April 2020.** **Rouge Valley Health System: Fully implemented.**	During our follow-up, we noted the following actions taken by the hospitals: **Trillium**: It implemented the Acute Care Surgery model at one of its sites in 2017/18, due to its demonstrated success at implementing it at another site in 2012 to help reduce the competition for operating rooms after hours by moving unplanned general surgery from evenings to daytime hours. It also plans to explore additional opportunities through a broader Operating Room Efficiency Analysis, which is expected to be completed by the end of March 2021. **Windsor**: It indicated that significantly more action is still needed to address this recommendation as it is still in the early stages of reviewing wait times for patients requiring surgery. As mentioned under **Recommendation 3**, it expects to develop an electronic system for documenting the reasons for delays by April 2020, after which it intends to identify ways to reduce the backlogs or delays for surgery. **Rouge**: It has implemented measures to reduce wait time and alleviate backlogs of urgent elective surgeries. For example, it has set up three Diagnostic Assessment Units (prostate, thyroid and breast) to reduce wait time from referral to diagnosis and surgery. It has also implemented swing rooms (two operating rooms with staggered operation start times and schedules that surgeons can "swing" between as their patients are ready) for orthopedic surgery. These swing rooms reduce the turnaround time of operating rooms and allow surgeons to perform two additional surgeries. In addition, it has put a physician assistant in place to help manage pre- and post-operative care, freeing up orthopedic surgeons to perform surgeries.

Committee Recommendation	Status Details
Recommendation 6 The Ministry of Health and Long-Term Care should work with hospitals to help ensure that both patients and health care providers make informed decisions, and that patients undergo elective surgery within an appropriate timeframe, by:	During our follow-up, we noted the following actions taken by the Ministry:
• implementing a centralized patient referral and assessment system for all types of elective surgeries within each region and between regions; **Status: In the process of being implemented by the end of March 2019.**	In December 2017, the Ministry announced an investment of $37 million over three years to expand the centralized patient referral and assessment system, known as Rapid Access Clinics (RACs), across the province for musculoskeletal care, starting with hip and knee replacement as well as low back pain management over 2017/18 and 2018/19. Some LHINs have started implementing the RACs for hip and knee replacement and for low back pain management. The Ministry expects that all LHINs will implement the RACs by the end of March 2019. Going forward, funding will be provided to test and evaluate the RACs for expansion to other types of surgeries or procedures.
• breaking down the wait-time performance data by urgency level for each type of elective surgery on the Ministry's public website; **Status: Fully implemented.**	The Ministry has introduced a new online tool to help people find wait-time performance data for surgeries and procedures by urgency or priority level across the province. In August 2017, wait-time information has been made available on both Health Quality Ontario's (HQO's) and the Ministry's websites. Wait-time data on the websites are broken down by priority level, which is assigned to each patient based on an assessment performed by clinicians to determine their urgency of care. There are four levels of priority: Priority 1 (Immediate/Emergency), Priority 2 (Urgent), Priority 3 (Semi-urgent) and Priority 4 (Non-urgent). Since patients with emergency conditions (Priority 1) are seen immediately, their wait times are not included in wait-time data. Each priority level of a procedure or surgery (such as cataract surgery, cancer surgery and orthopedic surgery) has an associated wait-time target. The websites show percentage of surgeries at each priority level completed within the associated target.
• timely (e.g., monthly) public reporting of the complete wait time for each type of surgery, including the time from the date of referral by primary care providers to the date of a patient's appointment with a specialist. **Status: Fully implemented.**	As mentioned above, as of August 2017, the Ministry has publicly reported wait-time performance data for surgical procedures on its and HQO's websites. Such data shows complete wait time by including two components: (1) the time between a referral received from a family physician or nurse practitioner and the patient's first appointment with a surgical specialist; and (2) the time between the decision on a surgery or procedure and the date of the surgery or procedure.

Committee Recommendation	Status Details
Recommendation 7 The Ministry of Health and Long-Term Care should ensure that patients receive timely elective surgery consultation from a specialist by identifying the reasons why there is a long wait for some specialists and working with the Local Health Integration Networks (LHINs), hospitals, and specialists to improve wait times and access to specialists and specialist services. **Status: In the process of being implemented by the end of March 2019.**	As mentioned under **Recommendation 6**, the Ministry has committed to improve access to specialist services by expanding the centralized patient referral and assessment system, known as Rapid Access Clinics (RACs), for patients who require hip and knee replacement as well as low back pain management. Some LHINs have implemented RACs, through which patients will receive an inter-professional assessment – typically a nurse practitioner, physiotherapist, or chiropractor with advanced skills and training – within four weeks of the referral and a determination will be made whether a surgical consultation is needed. Patients who do not require a surgery will be provided with non-surgical recommendations. The Ministry expects that all LHINs will implement the RACs by the end of March 2019. As well, the Ministry indicated that the RAC will be implemented based on the existing evidence-based models that have been proven to provide benefits to patients. These models include the Central Intake and Assessment Centre (CIAC) model and the Inter-professional Spine Assessment and Education Clinic (ISAEC) model. These models help patients who need surgery get faster access to surgical consultations and help develop self-management care plans for those who do not need surgery. The CIAC model, for example, has reduced wait times for hip and knee replacement in the Champlain LHIN by 90% by distributing patients across all surgeons' waiting lists.
Recommendation 8 The Ministry of Health and Long-Term Care should disseminate the report, "Association of delay of urgent or emergency surgery with mortality and use of health care resources: a propensity score-matched observational cohort study" (*Canadian Medical Association Journal*, July 10, 2017), to hospitals for their consideration. **Status: In the process of being implemented by September 2018.**	The Ministry informed us that communications of this nature are best delivered through the Ontario Hospital Association (OHA). The Ministry also indicated its Health System Quality and Funding Division will work with the OHA to disseminate this report to member hospitals by September 2018.

Committee Recommendation	Status Details
Recommendation 9 The Standing Committee on Public Accounts recommends that the Ministry of Health and Long-Term Care should ensure the safety of surgical patients by working with hospitals to ensure that hospitals regularly monitor and report on patient incident occurrences and take corrective actions as necessary. **Status: Fully implemented.**	The Ministry has worked with hospitals to ensure that hospitals regularly monitor patient incident occurrences and take corrective actions as necessary. For example: • The Ministry began funding the Ontario Surgical Quality Improvement Network (ON-SQIN), which brings together surgical teams from hospitals to assess clinical data, identify areas of focus in surgical safety and patient outcomes, and share ideas and practices. As of June 1, 2018, 46 Ontario hospitals have participated in the ON-SQIN, which has tracked and assessed 14 indicators from a patient's pre-surgery period to 30 days post-surgery, while adjusting the data for age and pre-existing illness to ensure comparability of findings. Examples of indicators include unplanned intubations, urinary tract infections, surgical site infections, sepsis, and venous thromboembolism. • The *Quality of Care Information Protection Act* (QCIPA), originally enacted in 2004, was amended and replaced by the QCIPA 2016, which came into force on July 1, 2017. The QCIPA 2016 increases transparency by affirming the rights of patients to access information about their own health care and clarifying that facts about critical incidents cannot be withheld from patients and their families. • The Ministry has continued to require all Ontario hospitals to report critical incidents relating to medication or intravenous fluids through the National System for Incident Reporting, a web-based tool that allows users to report, analyze and share information on patient safety incidents.
Recommendation 10 The Ministry of Health and Long-Term Care should make optimal use of health care resources for patients requiring hospital care and for those requiring long-term care by:	During our follow-up, we noted the following actions taken by the Ministry:
• ensuring that alternate level-of-care patients waiting in hospital are safe and receive the restorative and transitional care they need while they wait; **Status: Fully implemented.**	The Ministry has allocated about $40 million to the LHINs to support over 40 pilot projects and initiatives related to Assess and Restore interventions, which are short-term rehabilitative and restorative care services provided in the community to people who have experienced a reversible loss of their functional ability. At the time of our follow-up, services have been provided to about 28,000 seniors and training has been provided to over 2,000 clinicians. The hospitals and LHINs have reported improved access and patient flow from acute to sub-acute and rehabilitative beds, reduced length of stay at hospitals, and earlier discharge with the enhancement of in-home restorative services.
• conducting capacity-planning for senior care and addressing bed shortages, if any, in long-term care homes. **Status: Fully implemented.**	The Ministry has conducted capacity-planning for senior care and addressed bed shortages. In October 2017, the Ministry announced an investment of over 2,000 additional hospital beds to reduce wait times in hospitals. The Ministry has also worked with the LHINs and health service providers to enhance and expand supports available in the community. This partnership created about 600 transitional care spaces and 200 supportive housing units in 2017/2018 to assist patients transitioning out of hospitals and back to their own homes or in the community. To further increase the capacity of community care, the Ministry will be investing an additional $187 million in 2018/19.

Committee Recommendation	Status Details
Recommendation 11 The hospitals should help reduce the time that hospital patients must wait for beds after admission by:	During our follow-up, we noted the following actions taken by the hospitals:
• conducting a cost/benefit analysis in adopting more efficient bed-management systems that provide real-time information about the status of hospital beds, including those occupied, awaiting cleaning, or available for a new patient, as well as the number of patients waiting for each type of bed in each acute-care ward; **Status:** **Trillium Health Partners: In the process of being implemented by the end of March 2019.** **Windsor Regional Hospital:Fully implemented.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: Its 2017/18 capital allocations included up to $2 million for a bed-management system to improve patient flow and capacity management. The hospital was planning for next steps at the time of our follow-up. In June 2018, it engaged an external expert to review the current state of bed management, conduct a cost-benefit analysis, and recommend improvements. The cost/benefit analysis has been drafted and will be issued by the end of March 2019. **Windsor**: As mentioned under **Recommendation 2**, it has implemented a new bed-allocation model for the Medicine Program, as of October 2017, to move patients from the emergency department to the relevant ward quickly after admission. The new model uses a software program to display information about the status of hospital beds, such as the number of patients in the emergency department waiting for a bed, the length of time patients have been waiting, and bed-readiness status code of green (less than 30 minutes), yellow (31 to 60 minutes) or red (over 60 minutes). **Rouge**: Rouge's Centenary site (now Scarborough and Rouge Hospital) did not consider a cost-benefit analysis for a bed-management system because the merger of this site and The Scarborough Hospital provided the opportunity to leverage the existing systems at both hospitals. As a result, it has developed a Demand Capacity Board to supplement the existing bed-management system and improve the performance and accuracy of a web portal to view patient flow status. Rouge's Ajax/Pickering site (now Lakeridge Hospital) has developed the Bed Management Tool, an automated information system that tracks patient flow in real time.
• reviewing the times and days of the week where patients are waiting excessively at admission and discharge, and making necessary adjustments to allow sufficient time for beds to be prepared for new admissions, especially those patients arriving at peak times; **Status:** **Trillium Health Partners: In the process of being implemented by the end of March 2019.** **Windsor Regional Hospital: Fully implemented.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: Its Corporate Services has developed a plan for optimizing housekeeping activities to improve patient flow and allow sufficient time for beds to be prepared for new admissions. It has also addressed this recommendation through other initiatives such as the Capacity Management Processes and Practices framework and the Overcapacity Leadership Team as mentioned under **Recommendation 2**, and a cost-benefit analysis on bed management solution options as mentioned above. The cost-benefit analysis has been drafted and will be issued by the end of March 2019. **Windsor**: As mentioned under **Recommendation 2** and above, it has implemented a new bed-allocation model for the Medicine Program, as of October 2017, to move patients from the emergency department to the relevant ward quickly. The new model includes the use of assessment bays (where doctors can expedite diagnostic tests for patients, confirm their diagnosis, and establish an expected day of discharge). **Rouge**: It has established an Efficient Patient Flow Working Group, which has launched the following initiatives: revising the Bed Management and Surge Policy; streamlining daily bed-management meetings; and producing a daily Expected Date of Discharge report to help improve patient flow.

Committee Recommendation	Status Details
• ensuring that a sufficient number of housekeeping staff are on duty to clean recently vacated rooms and beds on a timely basis, and that the order of cleaning is prioritized based on the types of beds most in demand. **Status: All three hospitals: Fully implemented.**	**Trillium**: It completed a staffing analysis and implemented new staffing schedules in September 2017 to push start times for housekeeping staff later to cover times of higher housekeeping needs. It has added two five-hour shifts (ending at 11 p.m.) and three overnight shifts (ending at 7 a.m.) to address housekeeping needs later in the evenings. It has also set a target cleaning turnaround time of 45 minutes, which it monitors daily. It will continue to monitor discharge data and staffing schedules to ensure there is sufficient staff on hand to properly accommodate cleaning workloads. **Windsor**: It has restructured its cleaning staff, resulting in an increase of housekeeping staff available from 12 p.m. to 8 p.m. and from 11 p.m. to 7 a.m. to assist with discharge cleaning on afternoons and overnight. It has also changed its cleaning process so that the supervisor now assigns a housekeeper the task of cleaning a bed at the same time as assigning a porter the task of moving a patient out of the bed. This has saved 20 minutes in the cleaning process and improved housekeeping efficiency. **Rouge**: It has implemented a Priority Task System to identify and clean beds based on priority of patients. It has also implemented a Flow Focused Model by moving routine tasks (such as regular cleaning) to the end of day to reduce any duplication of efforts and better align available staffing with demand. In addition, it has implemented a surge-escalation plan to ensure that staffing is increased ahead of an anticipated increase in demand.
Recommendation 12 The Ministry of Health and Long-Term Care should ensure that hospitals, in conjunction with physicians, focus on making the best decisions for the evolving needs of patients, by reviewing the physician appointment and appeal process for hospitals and physicians under the *Public Hospitals Act*. **Status: Little or no progress.**	The Ministry indicated its commitment to develop a process to address this issue. The Ministry will consider this issue once it settles negotiations on the Physician Services Agreement between the provincial government and the Ontario Medical Association.
Recommendation 13 The Ministry of Health and Long-Term Care should ensure that hospitals are able to make the best decisions in response to the changing needs of patients by assessing the long-term value of hospitals employing physicians as hospital staff, and report on their progress in addressing this issue. **Status: Little or no progress.**	The Ministry indicated its commitment to develop a process to address this issue. The Ministry will consider this issue once it settles negotiations on the Physician Services Agreement between the provincial government and the Ontario Medical Association.

Committee Recommendation	Status Details
Recommendation 14 The hospitals should ensure better use of hospital resources for nursing care by:	During our follow-up, we noted the following actions taken by the hospitals:
• assessing the need for implementing a more efficient scheduling system, such as a hospital-wide information system that centralizes the scheduling of nurses based on patient needs; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has assessed the need for implementing a more efficient scheduling system and plans to enhance its Human Resources Information System with a system that provides more advanced functionality to support scheduling and proactive workforce planning or monitoring. It has developed requirements for the new system but has not yet determined the timing of implementation. **Windsor**: It has assessed the need for a more efficient scheduling system and implemented a scheduling program and a daily, shift-by-shift acuity tracker that manages its nursing levels based on patient needs. **Rouge**: It has assessed the need for a more efficient scheduling system and implemented an electronic scheduling system. It has also improved the system's communication capabilities by including a Shift Broadcast Notification feature that allows staff to send mass text messages to all units or departments. In addition, it has introduced a centralized staffing office model that allows all departments to review available staff resources in different areas to help fulfill scheduling needs.
• more robustly tracking and analyzing nurse overtime and sick leave; conducting thorough cost/benefit studies to inform decision-making on the use of different types of nursing staff without overreliance on agency nurses to fill in shortages; and reporting on their findings. **Status: All three hospitals: Fully implemented.**	**Trillium**: It has implemented additional due diligence for using overtime and agency nurses by requiring formal approval by Director. It has also begun issuing weekly reports to managers on overtime, sick leave and the use of agency nurses. In addition, it has examined nursing staffing ratios for all clinical areas, which are in line with the staffing ratios of peer hospitals. **Windsor**: It has engaged an external expert to review the staffing mix across all its patient care areas. It has also benchmarked its cost performance to peer hospitals and plans to review this annually. As part of this benchmarking, it has reviewed and analyzed its staffing mix, sick time and overtime. It does not use any agency nurses. **Rouge**: It has developed a quarterly scorecard for a senior management team to review the use of overtime, sick leave and agency nurses. It also requires approval by Director or Vice President for the use overtime and agency nurses. As well, it has used the Registered Nurse/Registered Practical Nurse Utilization Tool kit and the Patient Care Needs Assessment Tool to analyze the nursing care needs at an in-patient unit.

Committee Recommendation	Status Details
Recommendation 15 The hospitals should ensure the safety of patients and safeguard their personal health information through establishing effective processes to:	During our follow-up, we noted that the Ontario Hospital Association produced a document in July 2017 to guide hospitals when developing a criminal reference check program or enhancing an existing program. We also noted the following actions taken by the hospitals:
• perform criminal record checks before hiring new employees, and periodically update checks for existing staff, especially those who work with children and vulnerable patients; **Status:** **Trillium Health Partners: In the process of being implemented by December 2019.** **Windsor Regional Hospital: Fully implemented.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: It has developed a Criminal Reference Check Project Plan to perform criminal record checks on new hires and current employees. At the time of our follow-up, internal policy development was under way to support the phased implementation of criminal record checks by the end of December 2019. **Windsor**: It has implemented criminal record checks for all new employees, volunteers and professional staff. It also requires all existing employees to provide updated information if they have been subject to criminal charges or convictions after initial employment criminal checks. **Rouge**: It has implemented a Criminal Background Checks Policy, effective January 1, 2017, that requires satisfactory background checks for all board members, employees, physicians and volunteers. The Policy also requires all existing members of the workforce and contractors to submit a self-reporting form within two weeks of being formally charged with, or found guilty of, a criminal offence in any jurisdiction.
• deactivate access to all hospital information systems for anyone no longer employed by the hospital immediately after the employment ends; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has conducted a monthly audit to reconcile system accounts against individuals who have left the hospital to ensure that those accounts are closed. Its Human Resources and IT staff have also worked with managers to reduce the time between employee termination date and notification to Human Resources. **Windsor**: It has implemented a new process, called Active Directory Automation, through which any staff terminations made by its Human Resources department will automatically create a ticket to notify system managers. In addition, it has performed quarterly audits to validate if terminations have been completed. **Rouge**: It has developed a Service Access Request form to handle all staff terminations and deactivate terminated staff access to all hospital information. As a safeguard, its Human Resources department also sends a bi-weekly termination list to the IT team to ensure that all systems have been updated.
• where appropriate, implement adequate automatic logout functions for computers and any information systems containing patient information; **Status:** **Trillium Health Partners: Fully implemented.** **Windsor Regional Hospital: In the process of being implemented by December 2018.** **Rouge Valley Health System: Fully implemented.**	**Trillium**: It has implemented automatic logout after 30 minutes. **Windsor**: It was in the process of implementing a four-hour timeout process, which is expected to be completed by December 2018. **Rouge**: It has implemented automatic logout functions at two levels: 1) operating system, which is set to log out 30 minutes for most workstations; and 2) application, which varies according to the functionality offered by each vendor.

Committee Recommendation	Status Details
• encrypt all portable devices, such as laptops and USB keys, used by hospital staff to access patient information; **Status: All three hospitals: Fully implemented.**	**Trillium**: It had already encrypted all its portable devices, including the USB keys, at the time of our 2016 audit, and has continued to do so. **Windsor**: It completed its encryption policies in May 2018 and has encrypted all portable devices, including USB keys. **Rouge**: It enforces encryption of all hospital-provided devices, including portable devices such as mobile phones, laptops, notebooks and USB keys.
• assess the feasibility and practicality of replacing portable information devices such as USB keys and portable drives with such technologies as cloud computing and its equivalents to enhance information security. **Status:** **Trillium Health Partners: Fully implemented.** **Windsor Regional Hospital: Fully implemented.** **Rouge Valley Health System: In the process of being implemented by December 2018.**	**Trillium**: It has assessed the feasibility of replacing portable devices with cloud computing and decided to use only encrypted USB and portable storage devices as these methods are more secure than cloud-based services. **Windsor**: It has assessed the feasibility and practicality of replacing portable devices with cloud computing to enhance information security. For example, it has used SharePoint in the cloud to securely share and retain documentation. **Rouge**: Rouge's Centenary site (now Scarborough and Rouge Hospital) has obtained access to the OneDrive secure network folder technology. The corporate-wide rollout is expected to be implemented by December 2018. Rouge's Ajax/Pickering site (now Lakeridge Hospital), was in the planning stages for a cloud-based strategy for file-sharing and collaboration, which it expects to implement by December 2018.
Recommendation 16 The hospitals should ensure medical equipment functions properly when needed, and that both patients and health care workers are safe when equipment is in use, by:	During our follow-up, we noted the following actions taken by the hospitals:
• maintaining a complete inventory of medical equipment, with accurate and up-to-date information on all equipment that requires ongoing preventive maintenance; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has completed an inventory update by walking through every patient room and department to ensure that all medical devices have been entered into the database. It has introduced a new policy and procedures for inspecting and entering medical devices into the database, and retiring medical devices from the database when they are no longer in the hospital. **Windsor**: It has maintained a complete inventory of medical equipment by conducting an annual review of inventory during capital planning. During the annual review, the Biomedical Engineering Manager meets with the manager of each patient care area and reviews the inventory items. Inventory data is then updated in the Biomed Database System. **Rouge**: It has maintained a complete inventory of medical equipment and included such information in the Biomedical Engineering's Computerized Maintenance Management System database. It has also performed a review of the equipment maintenance management plan to ensure accurate and up-to-date information on all equipment.

Committee Recommendation	Status Details
• performing preventive and functional maintenance according to manufacturers' or other established specifications, and monitoring maintenance work to ensure that it is being completed properly and on a timely basis; **Status: All three hospitals: Fully implemented.**	**Trillium**: It has a preventive maintenance program in place for all critical medical devices based on manufacturer recommendations and best practices. It has performed annual audits to ensure that preventive maintenance has been completed on time. The latest audit was completed in November 2017. **Windsor**: Its preventive maintenance is scheduled on a medical device once it is received. A checklist is created that highlights all the tests outlined in the service manual. These tests are then checked off during each preventive maintenance. If there is a failure during preventive maintenance, corrective work is completed and another preventive maintenance is performed to ensure the medical device passes. The Biomedical Engineering Manager has daily meetings with the Lead Biomed to determine preventive maintenance compliance, shortfalls and/or challenges. A weekly automated preventive maintenance compliance report is generated and reviewed by the Biomedical Engineering Manager to ensure timelines are being met. **Rouge**: For Rouge's Centenary site (now Scarborough and Rouge Hospital), it has assigned a preventive maintenance strategy and schedule to each classification of device and recorded the schedule in a database to monitor inspection progress. The frequency of inspections is determined based on manufacturers' recommendations and other factors such as risk levels, industry standards, utilization, history and past experiences. Preventive maintenance work orders are automatically generated at the beginning of the month by the database and inspection results are recorded in the database. For Rouge's Ajax/Pickering site (now Lakeridge Hospital), its Clinical Engineering department has performed preventive maintenance on all medical equipment. During its merger with Lakeridge Hospital, an audit of all medical equipment was performed where asset numbers were assigned and preventive maintenance schedules were set up based on manufacturers' recommendations (every six months or 12 months) to create a new database for routine and scheduled preventive maintenance.
• monitoring the performance of preventive maintenance staff to ensure equipment is being maintained in accordance with appropriate scheduling. **Status: All three hospitals: Fully implemented.**	**Trillium**: For biomedical equipment, it has reported, on a quarterly basis, the completion rate of preventive maintenance based on equipment risk classification. For facilities assets, it has reported the preventive maintenance completion rate monthly. **Windsor**: It has performed routine semi-annual audits and annual performance reviews to monitor the biomedical engineering technicians who perform preventive maintenance. It has reviewed completed work orders monthly to ensure that each technician has followed manufacturer specifications and completed preventive maintenance as outlined in the service manual. As mentioned above, the Biomedical Engineering Manager has daily meetings with the Lead Biomed to determine preventive maintenance compliance, shortfalls and/or challenges. The Biomedical Engineering Manager generates and reviews a weekly automated preventive maintenance compliance report to ensure timelines are being met. In addition, the Manager generates a monthly metrics report, which outlines preventive maintenance compliance percentages and other key performance indicators, and shares it with Directors to check the status of preventive maintenance compliance and address challenges. **Rouge**: Rouge's Centenary site (now Scarborough and Rouge Hospital) has maintained inspection schedules and results in a database to monitor the progress and performance of inspection staff. It also affixes a yellow sticker on all medical equipment to indicate that it has undergone planned inspection and to show the next inspection date. Items that cannot be found are referred to clinical staff for help to locate them. Rouge's Ajax/Pickering site (now Lakeridge Hospital) has implemented a new Preventive Maintenance System to monitor maintenance schedule and staff performance. It has also assigned a manager to review outstanding maintenance work monthly.