Chapter 1
Section
1.01

Ministry of Health

Acute-Care Hospital Patient Safety and Drug Administration

Follow-Up on VFM Section 3.01, *2019 Annual Report*

This report contains two charts that show our recommendations that were directed to the Ministry of Health or Ontario hospitals. The Ontario hospitals we audited were Halton Healthcare, Hamilton Health Sciences, Humber River Hospital, Nipigon District Memorial Hospital, Pembroke Regional Hospital, Thunder Bay Regional Health Sciences Centre, The Ottawa Hospital, Women's College Hospital, Chatham-Kent Health Alliance, Grand River Hospital, Northumberland Hills Hospital, Stratford General Hospital, and St. Thomas Elgin General Hospital.

RECOMMENDATION STATUS OVERVIEW

Recommendations Applicable to Ministry of Health	# of Actions Recommended	Status of Actions Recommended				
		Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 2	3			3		
Recommendation 4	1			1		
Recommendation 5	2	1	1			
Recommendation 7	2		2			
Recommendation 8	1		1			
Recommendation 9	2			2		
Recommendation 10	2		2			
Recommendation 11	1		1			
Recommendation 12	2		1	1		
Recommendation 14	3	1		2		
Recommendation 17	1			1		
Recommendation 22	1	1				
Total	**21**	**3**	**8**	**10**	**0**	**0**
%	**100**	**14**	**38**	**48**	**0**	**0**

RECOMMENDATION STATUS OVERVIEW

Recommendations Applicable to Hospitals	# of Actions Recommended	Status of Actions Recommended: Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	1	0.54	0.23		0.23	
Recommendation 3	3	0.31	0.13	0.41	0.13	0.03
Recommendation 6*	2	0.14	0.04	0.32	0.21	0.29
Recommendation 13	1	0.61	0.31			0.08
Recommendation 15	3	0.85	0.15			
Recommendation 16	1	0.54	0.23	0.08	0.15	
Recommendation 18	1	0.23	0.23	0.39	0.15	
Recommendation 19	2	0.70	0.15			0.15
Recommendation 20	1	0.61	0.08	0.08	0.08	0.15
Recommendation 21	2	0.27	0.04			0.69
Total	**17**	**8.16**	**2.36**	**2.44**	**1.45**	**2.59**
%	**100**	**48**	**14**	**14**	**9**	**15**

* Note: During the 2019 audit planning stage, we conducted walkthroughs at Trillium Health Partners (THP), which was one of the hospitals audited in our 2016 audit report of Large Hospital Operations. In the 2019 audit, we limited our audit work at THP to Human Resources.

Overall Conclusion

The Ministry of Health and the Ontario hospitals, as of September 30, 2021, have fully implemented 14% and 48% respectively of the actions we recommended in our *2019 Annual Report*. The Ministry has made progress in implementing an additional 38% of the recommendations and the Ontario hospitals have made progress in implementing an additional 14% of the recommendations.

The Ministry has fully implemented some recommendations such as identifying the gaps in the information sharing between the College of Nurses of Ontario and health system partners, for example, nurses may have multiple employers and an ongoing investigation in connection with services provided at one health facility that may not be known at the other work location. In March 2021, the Ministry publicly released the medication safety quality standard that addresses care in all settings relevant to medication safety, including primary health care, specialist health care, long-term care, and home and community care for people of all ages who are taking one or more medications. In addition, a province-wide "command centre" has been implemented, which collects and analyzes, in real-time, the patient bed flow of each acute-care hospital in Ontario. This "command centre" is supporting Ontario's COVID-19 pandemic response and will continue to operate thereafter.

The Ontario hospitals we visited have fully implemented recommendations such as having medication reconciliation policies and procedures in place, having dedicated staff to do the medication reconciliation and review to ensure completeness, and providing ongoing education to nursing and pharmacy staff on completing medication reconciliation. In addition, all Ontario hospitals we visited have policies in place for medication administration processes, and more than half of the hospitals have implemented or are in the process of implementing the hospital information system (HIS) that uses bar code scanning of patients and medications by the nurse, thereby providing additional safety checks when administering medication.

However, the Ministry has made little progress on 48% of the recommendations due to the COVID-19 pandemic, including reducing the impact of never-events on patient safety and the health-care system, establishing a forum where hospitals can share their

knowledge and lessons learned from patient safety incident investigations, and exploring the means to allow 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. Some Ontario hospitals we visited have made little or no progress on some of the recommendations due to the COVID-19 pandemic. In addition, some of these hospitals will not set a formal target to eliminate the occurrence of never-events and will not include this in their Quality Improvement Plans because some hospitals have noted that this is not a mandatory target established by Ontario Health and are awaiting direction from them. Due to the COVID-19 pandemic, discussions about quality improvement plan indicators have been on hold. Also, some hospitals will not implement some of our recommendations because they continue to rely on the nurses' registration and disciplinary status with the College of Nurses of Ontario and rely on nurses truthfully answering on their application on whether he or she held a nursing license or practiced in a jurisdiction other than Ontario; however, this does not address the risk that the nurse may fail to disclose complete information about their license status and disciplinary record from other jurisdictions, and the College of Nurses of Ontario would not detect this due to the lack of a single repository for Canadian nurse registration and discipline information.

The status of actions taken on each of our recommendations is described in this report.

Background

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.

Our audit focused on patient safety in acute-care hospitals, where patients primarily receive active short-term treatment. Under the *Public Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and to take steps to prevent similar incidents from occurring in the future. However, 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.

Hospital data collected by the Canadian Institute for Health Information shows that each year, among the more than 1 million patient discharges from Ontario acute-care hospitals, approximately 67,000 patients were harmed during their hospital stays. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital.

While the majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals we visited are committed to patient safety, our audit found that more could be done to improve patient safety.

Among our significant 2019 audit findings:

- Practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Non-disclosure arrangements negotiated by unions with hospitals could result in potential new employers not being made aware of nurses' poor past performance.
- Nurses that acute-care hospitals had found to lack competence and who had been terminated or banned continued to pose a risk to patient safety. (Agency nurses found incompetent may be banned by hospitals.) We reviewed a sample of nurses who were terminated or banned for lack of competence in the previous seven years from nine hospitals that we visited. After their first termination or banning, 15 of the nurses subsequently worked at another hospital or for another agency. We noted that four of them were either subsequently terminated or banned again for lack of competence.
- Patient safety culture at different hospitals varied significantly, from excellent to poor and failing. We obtained the most recent staff survey results from all 123 acute-care hospitals in Ontario,

completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."

- Patient safety "never-events" had occurred at most of the acute-care hospitals we visited. Health Quality Ontario and the Canadian Patient Safety Institute have identified 15 patient safety "never-events"—preventable incidents that could cause serious patient harm or death. We found that since 2015, 10 out of the 15 never-events had occurred a total of 214 times in six of the 13 hospitals that we audited.
- Acute-care hospitals did not always follow best practices for medication administration. From 2012 to 2018, hospitals in Ontario reported to the Canadian Institute for Health Information 154 critical patient safety incidents involving administration of medications. Thirty-nine of these incidents resulted in a patient's death. We found that three of the hospitals we visited did not comply with best practices for the administration of high-risk medications.

We made 22 recommendations, consisting of 38 action items, to address our audit findings.

We received commitment from the Ministry of Health and the Ontario Hospital Association that they would take action to address our recommendations.

Status of Actions Taken on Recommendations

We conducted assurance work between July 2021 and September 2021. We obtained written representation from the Ministry of Health and the 14 Ontario hospitals that effective November 18, 2021, they have provided us with a complete update of the status of the recommendations we made in the original audit two years ago. Ontario Hospital Association was unable to assist the hospitals this year with co-ordinating their responses to our recommendations because of the COVID-19 pandemic.

Focus on Patient Safety Not Consistent between Hospitals

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.

Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we found that "patient safety" is not explicitly stated in the mission, vision and core values for most hospitals that we visited in a way that would foreground the phrase as the foundation for the organizational culture of these hospitals. When we reviewed the mission, vision and core values of the 13 hospitals that we audited, we found that not all of them made a clear and direct reference to patient safety and quality of care. The other hospitals mention quality, excellence and compassion—but not specifically patient safety.

In our follow-up, we found that half of the hospitals have fully implemented this recommendation and have made a clear and direct reference to patient safety and quality of care.

For the other hospitals,

- Of the hospitals that are in the process of implementing this recommendation, one hospital is still in the process of updating its mission, vision, and values and is aiming to complete this by January 2022. Although a hospital is in the process of implementing this recommendation by April 2023 during its next strategic planning process, we found that quality and safety is currently stated in its shared (internal and external stakeholders) purpose statement, however the

hospital will review it to state patient safety more explicitly.

- Three hospitals will not implement this recommendation. Although patient safety is the number one priority for all of these hospitals, one hospital's mission, vision, values and strategic plan that incorporated excellent patient care were already implemented and will be in place until 2024. The other hospitals refer to care and quality in their vision, mission statements and Patient Safety Plan.

The Office of the Auditor General continues to believe that this is a significant recommendation and continues to 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.

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.*

  Status: Little or no progress.

Details

We found in our 2019 audit that between the 2015/16 and 2018/19 fiscal years, 10 out of the 15 never-events (events that are preventable and should never occur in hospitals) occurred a total of 214 times in six of the 13 hospitals we visited that tracked these incidents. Data was not available or never-events did not occur at the other seven hospitals we visited.

In our follow-up, we found that the Ministry of Health is in the initial stages of engaging Ontario Health as a key partner to support the approach on tracking hospital never-events data in the hospital sector. The Ministry, in partnership with Ontario Health, will conduct a preliminary assessment to leverage a current data collection tool that can accumulate and track hospital never-events data. As well, the Ministry told us that it plans to conduct hospital sector consultations to understand key business requirements that will help inform the stakeholder outreach plan and engagement approach in the future. This work has been paused because of the COVID-19 pandemic.

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;*

  Status: In the process of being implemented by June 2022.

Details

In our 2019 audit, we noted that identifying and preventing these safety events was identified as a priority by a patient safety consortium of more than 50 Canadian health-care organizations in 2014. According to broad stakeholder consensus, "never events" are preventable and should never occur in hospitals. An organizational culture that minimizes or eliminates never-events could foster a reduction in other preventable patient harms.

In our follow-up, we found that almost all of the 13 hospitals have patient safety practices in place to eliminate the occurrence of never-events. For example, hospitals have developed quality and safety policies and procedures to reduce or eliminate occurrences of never events, including identifying and learning from these incidents in order to prevent recurrence. For the remaining hospitals, one hospital is in the process of implementing this action item by

proposing a plan for never-events to their corporate quality and patient safety committee, and the other hospital has made little or no progress because of a change in its Quality and Patient Safety Leadership, which, coupled with the COVID-19 pandemic, has delayed its efforts. All of the 13 hospitals internally report the never-events in their electronic incident reporting system for their review and to prevent recurrence.

- *set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans;*

  Status: In the process of being implemented by December 2022.

In our 2019 audit, we found that none of the six hospitals set targets in their Quality Improvement Plans to minimize or eliminate the occurrence of never-events. Two other hospitals we visited included one of the never-events—serious pressure ulcer acquired after admission to hospital—in their Quality Improvement Plans for 2018/19. No never-events were reported at these hospitals.

In our follow-up, we found that one hospital has fully implemented this action item by including never-events as a metric with a target of zero in its Quality, Risk and Safety Scorecard. Due to COVID-19, the 2020-21 Quality Improvement Plans (QIPs) have been paused, however, once Ontario Health resumes the QIPs this hospital will include its never-events target in its QIP. Two hospitals have set formal targets to reduce the occurrence of some never-events, for example, serious pressure ulcer acquired after admission to hospital, however, this is not currently included in the hospitals' QIP, because, as indicated above, due to the COVID-19 pandemic QIPs have been paused. One hospital has set a formal target of zero for never-events and by end of 2022 will review the events to report on. Two hospitals are specifically identifying an incident as a never-event in their incident reporting system as well as planning to set a target to eliminate the occurrence of never-events and add it in their next QIP. One hospital has indicated that pressure ulcer is a key focus for the coming year and a target will be determined once reliable baseline measures are established. One hospital has set a formal target of zero for never-events and made this public through its annual Patient Safety Plan but will not include this target in its QIPs.

Although all hospitals are tracking the occurrence of critical incidents and never-events and reporting the results internally to their senior leadership team, about half the hospitals have not progressed or will not set a formal target to eliminate the occurrence of never-events and will not include this in their QIPs because some hospitals have noted that this is not a mandatory target established by Ontario Health and are awaiting direction from it; their focus continues to be on the pandemic response; and some hospitals have internally reported zero never-events on an annual basis but some hospitals have noted that if an incident should occur the hospital would consider setting a formal target and including it in their QIP. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to recommend that hospitals set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans.

- *track and report never-events to the Ministry of Health.*

  Status: Little or no progress.

In our 2019 audit, we found that 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. Hospitals report various patient safety statistics to different organizations, both government and not-for-profit. Some of the reporting is mandatory, whereas other information is reported voluntarily. All 13 hospitals have internal reporting systems to keep track and document all patient incidents, including never-events, however there is no formal mechanism in place to facilitate the reporting of these incidents to the Ministry of Health or Ontario Health. Such information could be analyzed to determine the reasons for these events in Ontario, the cost

that these events add to the health-care system and the systemic best practices to adopt to avoid these events. We noted that hospitals in Saskatchewan and Nova Scotia are required to track and report never-events to their respective health ministries.

In our follow-up, we found that the hospitals are awaiting direction from the Ministry of Health to report these never-events to them through a reporting system. Refer to **Recommendation 2** for the implementation and rollout of this reporting system.

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.

Status: Little or no progress.

Details

In our 2019 audit, we found that the hospitals we visited were committed to the objective of learning from incidents occurring at their own sites and improving the safety and quality of patient care. However, hospitals do not share lessons learned from investigating specific patient safety incidents. This increases the risk that a patient could experience an incident at Hospital A, and another patient could subsequently experience a similar incident at a neighbouring Hospital B. Hospital A does not share lessons learned with Hospital B in order to help prevent the same type of incident.

In our follow-up, we found that this work has been paused because of the COVID-19 pandemic, however once resumed, Ontario Health will work with applicable stakeholder groups to develop a knowledge sharing platform.

Some Nurses Found by Hospitals to Lack Competence Pose an Ongoing Risk to Patient Safety

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;*

  Status: Fully implemented.

Details

In our 2019 audit, we found that some nurses were found to lack competence and who have been terminated by hospitals have been associated with repeated incidents impacting patient safety. Hospitals that rehire them are limited in the information regarding past poor performance that they can obtain from the College of Nurses of Ontario and from past employers. We also found that when one hospital banned an agency nurse, this did not prevent the nurse from working at other hospitals, and this information was not shared by the agencies or the hospitals involved.

In our follow-up, we found that the Ministry of Health worked with the health sector to identify gaps in the information sharing between the College of Nurses of Ontario and health system partners. The gaps identified were that nurses may have multiple employers and an ongoing investigation in connection with services provided at one health facility (e.g., a hospital or a long-term-care home) where the complaint was filed at one location may not be known at the other work location; and the threshold for disclosure and the purposes for the disclosure would need to be developed so as to balance both public safety and procedural fairness.

- *take steps to address gaps identified.*

  Status: In the process of being implemented by August 2025.

Details

In our 2019 audit, the College of Nurses of Ontario (College) informed us that the *Regulated Health Professions Act* limits the information it is able to share with hospitals and any member of the public with respect to nurses terminated and reported by other hospitals to the College. Hospitals also informed us that if they contact the College to obtain information about a prospective nurse employee, they are usually referred to the nurse's public profile, which does not have information on ongoing investigations and may have incomplete information.

In our follow-up, we found that the Ministry of Health is working with the health sector to address gaps in information sharing between colleges and health system partners. As part of its continuing efforts to improve transparency and increase information sharing between employers and the health regulatory colleges, the College and the Ministry have worked to add information about a nurse's employers from the past three years on the College's public register so that employers have a reliable way to obtain employment information about nurses. The College has also worked to include all current employers on the public register. Since many nurses have more than one employer, this will provide a more accurate picture of a nurse's employment. During our 2019 audit, we observed that this reporting of a nurse's employers from the past three years on the College's public register was already in place.

Also, work is currently under way to link information in better ways, such as through the voluntary Employer Reference Group established by the College partnering with nurse employers. This Employer Reference Group meets on a quarterly basis to identify areas to support employers' needs relating to nursing regulation. The Employer Reference Group has been working on a number of initiatives during 2020 and 2021 to address the gaps identified above. For example, a revised reporting guide was developed outlining the steps involved when filing a professional conduct report, and new resources on harm prevention were developed and shared through videos that raised awareness about the possibility of nurses and other health-care providers intentionally harming patients. The College has authored an article about health care serial killers that was published by the Journal of Nursing Regulation. The article includes findings from a comprehensive literature review and makes suggestions to detect and prevent health care serial killing. In addition, the implementation of NURSYS Canada, a national database for sharing nurse registration and discipline information across jurisdictions by August 2025 (see **Recommendation 7**), will also address the gaps identified above.

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;*

  Status: In the process of being implemented by December 2021.

Details

In our 2019 audit, we found that five of the 200 nurses we sampled, (from the 182,000 registered in Ontario and matched the information found in the College database with the National Council of State Boards of Nursing public database and the Michigan Board of Nursing), reported that Ontario was the only place where they held a licence. However, we found that these five nurses were also licensed in other jurisdictions, such as Michigan. Another four nurses reported that they held a licence in Ontario and one US state, but we found that these four nurses also held licences in at least one additional state. The College of Nurses of Ontario's (College) public profile for these nurses therefore is incomplete. We also found that hospital and agency hiring decisions are mostly based on information found in resumés. In March 2019, the College changed the nurse profile template to show not only a nurse's current employer, but a nurse's employment history as well. However, the College left it up to each individual nurse to update their own

employment history. Despite these changes, we have noted that there are nurses in our sample whose self-reported employment history on their College profile omits hospitals where they were terminated for patient safety reasons.

In our follow-up, we found that only four hospitals have fully implemented this action item by confirming nurse applicant registration through the US public database regardless of the country the nurse is coming from, including Canada. One hospital intends to incorporate the use of the National Council of State Boards of Nursing public database into their standard screening process for new hires by December 2021. Less than half of the hospitals will consider this action item and will start looking into using the National Council of State Boards of Nursing public database; however, the hospitals are relying on information about the nurses' registration and disciplinary status with the College to ensure the nurses have no restrictions on their licences. We found that four hospitals will not be implementing this action item because these hospitals rely on the nurses' registration and disciplinary status with the College and rely on nurses truthfully answering on their application on whether he or she held a nursing licence or practiced in a jurisdiction other than Ontario. However, this does not address the risk that the nurse may fail to disclose complete information about their licence status and disciplinary record from other jurisdictions, and the College would not detect this due to the lack of a single repository for Canadian nurse registration and discipline information, since NURSYS Canada, a national database for sharing nurse registration and discipline information across jurisdictions, will not be implemented until August 2025. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to 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 until the College implements NURSYS Canada.

- *if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.*

  Status: Little or no progress.

Details

In our 2019 audit, we found that nurses who hospitals have found lack competence and who have been terminated or banned continue to pose a risk to patient safety. We reviewed a sample of nurses who were terminated for lack of competence and/or inappropriate conduct, and agency nurses that were banned, in the past seven years in nine of the 13 hospitals we visited. (Agency nurses who are found incompetent may be banned by a hospital.) After their first termination or banning, 15 of the nurses subsequently worked at another hospital or for another agency. We noted that four of them were either subsequently terminated or banned again for lack of competence. For example, one nurse who currently works as an agency nurse was, between May 2016 and March 2019, terminated from two hospitals and also banned from a third hospital for lack of competence.

In our follow-up, we found that only six hospitals use agency nurses. Four out of the six hospitals will consider this action item for nursing agencies but little or no progress has been made for a number of reasons, including their efforts have been to respond to the COVID-19 pandemic, time will be needed to advise the agency partner of the requirement and amendments to the agency contract agreement may need to be done, or the hospital is looking into privacy concerns. One hospital will not be implementing this recommendation because of its focus on the pandemic response and its inability to verify that agencies are consulting the US national database. Another hospital will not be implementing this action item because the hospital requires all agency nurses to be in good standing with the College of Nurses of Ontario (College). However, as stated above, this does not address the risk that the nurse may fail to disclose complete information about their license status and disciplinary record from other jurisdictions, and the College would not detect this due to the lack of

a single repository for Canadian nurse registration and discipline information, since NURSYS Canada, a national database for sharing nurse registration and discipline information across jurisdictions, will not be implemented until August 2025. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to recommend that if the hospital uses agency nurses, it should require nursing agencies to confirm these nurses have been screened through the National Council of State Boards of Nursing public database until the College implements NURSYS Canada.

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.*

Status: In the process of being implemented by August 2025.

Details

In our 2019 audit, we found that in Canada, there is currently no centralized system to which all provincial nursing regulatory bodies like the College of Nurses of Ontario can report their disciplinary actions. In the United States, regulatory bodies from each state are required to report all their disciplinary actions within 30 days to the National Practitioner Data Bank, a hospital-accessible database operated by the federal government. Hospitals in the United States can check whether nurses they hire are listed in this database for disciplinary actions. There is also a second public database operated by the National Council of State Boards of Nursing (NCSBN), which tracks disciplinary actions from every state (except Michigan) and also shows the jurisdictions where each nurse holds or has held a licence. Hospitals from around the world can check whether nurses they hire are listed in this database for disciplinary action.

In our follow-up, we found that the College of Nurses of Ontario (College) is working with other Canadian regulators to implement a national database for sharing nurse registration and discipline information across jurisdictions. NURSYS Canada is a national project under the joint leadership of the B.C. College of Nurses and Midwives (BCCNM) and the College. They have partnered with the National Council of State Boards of Nursing (NCSBN) to develop an electronic repository for Canadian nurse registration and discipline information. NURSYS Canada will enhance public protection by allowing all nurse regulators across Canada to review and exchange the relevant information needed to verify it is safe to permit a nurse to work across provincial and territorial jurisdictions. While NURSYS Canada is a Canadian system, it will be possible to more efficiently and effectively exchange information with nursing regulators in the United States, since it is based on the American system developed by the National Council of State Boards of Nursing.

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.

Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we found that the potential risk of civil legal actions could prevent hospitals from disclosing a complete employment history record of a nurse

to their potential new employer. As a result, during an employment reference check, hospitals may not freely share with potential employers a nurse's detailed work history record—for instance, that a nurse lacked competence and failed to complete a learning plan on several attempts. Only information about employment dates, hours worked and the role the employee held or holds in the hospital is usually shared with potential employers. Other important performance information remains confidential. We also found that jurisdictions in the United States, such as New Jersey, have specific legislation in place that protects hospitals and other health-care providers from liability associated with any civil legal action for disclosing a complete and truthful record about a current or former nurse to a prospective employer. Similar legislation does not exist in any Canadian jurisdiction. We have noted as well that other US states, such as Pennsylvania, North Carolina and Texas, have similar laws that extend legal protection to all employers and not just health-care providers.

In our follow-up, we found that the Ministry of Health developed a jurisdictional questionnaire and sent it to five provinces or territories (Nunavut, Nova Scotia, Alberta, Northwest Territories and Saskatchewan) to seek information to help inform it of the applicability in Ontario 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. To date, the Ministry has obtained the responses from all five provinces or territories, but the analysis of the scan has not been completed. The Ministry informed us that once the analysis of the scan is done, it will conduct internal consultations with Ministry program areas and engage with external stakeholders as required. Based on the scan and consultations, the Ministry told us that it estimates that by December 2021 options will be developed, barring a fourth wave of the COVID-19 pandemic. However, the Ministry's progress has been delayed because of the Ministry's and hospital sector's response to the COVID-19 pandemic.

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.*

Status: Little or no progress.

Details

In our 2019 audit, we found that almost all Ontario nurses are unionized, although agency nurses are not unionized. A nurse facing disciplinary action can approach his or her union for help. The union would then represent the nurse and try to negotiate with the hospital the most favourable disciplinary outcome for the nurse. For instance, the union could ask the hospital to treat the termination as a resignation or negotiate a non-disclosure arrangement; the nurse's disciplinary history would then be kept hidden in the confidential records of the hospital the nurse has departed from until the College of Nurses of Ontario (College) completes its disciplinary investigation, if the College chooses to undertake one. We found that this practice can prevent hospitals from knowing about a nurse's past performance to use in their hiring decisions in order to minimize potential harm to patients.

In our follow-up, we found that due to competing priorities and COVID-19 pandemic responses, an opportunity has not been available for the Ministry to examine the *Regulated Health Professions Act* (RHPA) in this regard. The RHPA provides a regulation that permits the government to prescribe purposes for which disclosures can be made under specific clauses from the College of Nurses of Ontario to public hospitals or other named/described persons of certain information stemming from its investigations. The Ministry will examine existing regulation-making

powers that could permit Colleges, including the College of Nurses of Ontario, to disclose relevant investigation information to hospitals.

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.*

Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we found that in most cases hospitals do not conduct periodic criminal record checks of currently employed nurses. Our 2016 audit of Large Community Hospital Operations found that some hospitals did not conduct initial and/or periodic background checks, and in our 2018 follow-up report only three hospitals that we audited as part of our 2016 Large Community Hospital Operations audit (Trillium Health Partners, Windsor Regional Hospital and Rouge Valley Health System) currently conduct, or will soon start conducting, periodic criminal record checks of their nurses. The other hospitals that we visited as part of the 2019 audit do not. 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.

In our follow-up, we found that the Ministry of Health developed a jurisdictional questionnaire and sent it to five provinces or territories (Nunavut, Nova Scotia, Alberta, Northwest Territories and Saskatchewan) to seek information to help inform it of the applicability in Ontario to perform criminal record checks before hiring nurses and other health-care employees, and periodically update checks for existing staff. To date, the Ministry has obtained the responses from all five provinces or territories, but the analysis of the scan has not been completed. The Ministry informed us that once the analysis of the scan is done, it will conduct internal consultations with Ministry program areas and engage with external stakeholders as required. Based on the scan and consultations, the Ministry told us that it estimates that by December 2021 options will be developed, barring a fourth wave of the COVID-19 pandemic. However, the Ministry's progress has been delayed because of the Ministry's and hospital sector's response to the COVID-19 pandemic.

Disciplining Physicians Is Difficult and Costly—Legal Costs Are Indirectly Subsidized by Taxpayers

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.

Status: In the process of being implemented by April 2023.

Details

In our 2019 audit, we found that hospitals still are not able to quickly and cost-effectively deal with physicians that hospitals find may have practice issues, lack competence and may pose patient safety concerns. Once a competency and/or practice issue has been identified, hospitals must work through a lengthy process to determine whether the physician's privileges can be revoked, restricted or not renewed. While the disciplinary process is ongoing, physicians can continue to work, even at multiple hospitals, unless the hospital puts an emergency stop to a physician's work due to an immediate risk to patient safety. In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers through a liability insurance reimbursement program. Through this program, the Ministry reimburses physicians for enrolling either in the Canadian

Medical Protective Association, a not-for-profit association that provides lawyers to represent physicians, or in any other organization they choose to purchase medical liability protection from. Disciplinary cases can take several years and cost hospitals hundreds of thousands of dollars in their own legal fees and other costs. In our 2016 audit of Large Community Hospital Operations, we reported that hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the *Public Hospitals Act*. We recommended that the Ministry evaluate this problem.

In our follow-up, we found that the Ministry of Health developed a jurisdictional questionnaire and sent it to three provinces (Alberta, British Columbia and Saskatchewan) to seek information to help inform it of the applicability in Ontario 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. To date, the Ministry has obtained the responses from all three provinces, but the analysis of the scan has not been completed. The Ministry informed us that once the analysis of the scan is done, it will conduct internal consultations with ministry program areas and engage with external stakeholders as required. Based on the scan and consultations, the Ministry told us that it estimates that by December 2021 options will be developed, barring a fourth wave of the COVID-19 pandemic. However, the Ministry's progress has been delayed because of the Ministry's and hospital sector's response to the COVID-19 pandemic.

Hospital Accreditation Reports Highlight Gaps in Compliance

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;*

  Status: Little or no progress.

Details

In our 2019 audit, we found that between 2014 and 2019, 18 hospitals did not comply with five or more required practices that are central to quality and patient safety. We noted that 148 practices in the six practice areas deemed central to the quality and safety of care were not complied with at 18 out of 114 hospitals. As well, we found that 13 out of the 114 hospitals did not meet between 5% and 11% of their high-priority patient safety criteria when assessed. Accreditation Canada assesses each hospital against a number of criteria that it uses to measure the hospital's compliance with standards that contribute to high-quality, safe and effectively managed care. High-priority criteria relate to safety, ethics, risk management and quality improvement, and have an impact on patient safety. These criteria weigh heavily in determining whether a hospital meets the accreditation standards. We found that as a group, the 114 hospitals did not meet 1,707 high-priority criteria relating to patient safety standards in the above two categories.

In our follow-up, we found that the Ministry of Health and Ontario Health have not collected the Accreditation Canada reports from hospitals to review and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria. Since the Accreditation Canada reports are the property of each individual hospital, Ontario Health will explore the opportunity for this information sharing. The Ministry plans on working with Ontario Health to ensure that hospital patient safety practices are reviewed and assess how patient safety in hospitals is being addressed to address potential deficiencies.

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

Status: In the process of being implemented by March 2022.

Details

In our 2019 audit, we noted that Accreditation Canada conducts its visits at hospitals every four years, so it is unknown for how long prior to the visit hospitals did not have the required patient safety practices in place.

In our follow-up, we found that although the Ministry of Health and Ontario Health have not collected the Accreditation Canada reports from hospitals to review and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria, the Ministry has included patient safety as a priority in the 2020-2021 and 2021-2022 Ontario Health Mandate Letters. Ontario Health's mandate includes holding health-care providers accountable for health system performance and quality by undertaking a review of the Accountability Agreements with health-service providers and working closely with the Ministry of Health to outline roles and responsibilities related to accountability and performance management because further investigation is required to outline patient safety elements of accountability. Also, Ontario Health updated its publicly reported indicators on hospital patient safety through 2020-21 on the Health Quality Ontario platform. As well, Ontario Health, via the Health Quality Ontario platform, publicly reports on medication safety. As stated above, Ontario Health will review the Accountability Agreements and the current set of publicly reported patient safety indicators and work with the Ministry of Health to implement changes in patient safety quality improvement and performance management.

Best Practices Not Always Followed for Medication Administration

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.

Status: In the process of being implemented by February 2022.

Details

In our 2019 audit, we found that hospitals that we visited informed us that medication reconciliation is a labour-intensive process and that is why sometimes they are not able to complete all the required reconciliations. Reconciling medication for patients who take a large number of medications and purchase them from several pharmacies can take more than 24 hours, as the hospital has to contact each pharmacy to compile the patient's medication history.

In our follow-up, we found that the majority of hospitals have fully implemented this recommendation by having medication reconciliation policies and procedures in place, having dedicated staff to do the work and review it to ensure completeness, provide ongoing education to nursing and pharmacy staff on completing medication reconciliation, and some hospitals audit monthly a sample of patients' charts to ensure medication reconciliation is done at admission and discharge with the results shared with staff for continuous improvement. One hospital established a medication reconciliation task force to reinforce the importance of medication reconciliation on a corporate level. Other hospitals are in the process of implementing this recommendation because resources continue to be a challenge given the shortage of pharmacy technicians and are using pharmacy students or physicians for conducting medication reconciliation. Some hospitals have noted that the upcoming implementation of their new hospital information system (HIS) will assist staff and patients with the reconciliation processes.

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;*
  Status: Fully implemented.

Details

In our 2019 audit, at each of the five hospitals we visited, we reviewed 10 completed medication reconciliations to assess how they are performed and documented. We found that each hospital documents the reconciliations differently, and at four of the five hospitals we found at least one reconciliation that was missing some important information. In total, 20 out of the 50 completed medication reconciliations we reviewed were missing information such as patients' medication history, medication dosage and quantity prescribed on discharge, and the time of the last dose taken. Without this information, on release from hospital patients may not be instructed to take their medication appropriately in order to prevent harm.

In our follow-up, we found that during 2020-21, Ontario Health developed a quality standard on medication safety that will support hospitals and other health-care settings in their efforts to reduce errors and risks related to medication use and administration. The medication safety quality standard was publicly released in March 2021 and addresses care for people of all ages who are taking one or more medications. It focuses on care in all settings relevant to medication safety, including primary health care, specialist health care, long-term care, and home and community care. Also, Ontario Health publicly made available a patient guide to medication safety that accompanies the quality standard on medication safety. The guide outlines the top five areas to improve care for people taking one or more medications – one area being an accurate and up-to-date list of medications is available to people taking medication (and their families and caregivers, as appropriate) and to relevant health care professionals. During Patient Safety Week in fall 2021, Ontario Health plans to present the publicly released medication safety quality standard to align with several provincial webinars. One webinar will focus on a broad healthcare audience in partnership with the Institute for Safe Medication Practices Canada. Another webinar will focus on reaching pharmacists in partnership with the Ontario College of Pharmacists and linking this standard to their Assurance and Improvement in Medication Safety (AIMS) quality improvement program.

- *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.*
  Status: Little or no progress.

Details

In our 2019 audit, we found that for 2018/19, Health Quality Ontario recommended that hospitals focus on conducting medication reconciliation for patients that they discharge and add this to their Quality Improvement Plans. This is not a mandatory requirement, and only 78 hospitals included it in their 2018/19 Quality Improvement Plans. Based on information reported by these 78 hospitals to Health Quality Ontario, on average they completed medication reconciliation for only 76 out of every 100 patients where reconciliation at discharge was required. This means that, on average, about 24 out of every 100 patients discharged from the hospital did not have a medication reconciliation completed at discharge.

We visited five hospitals to review their medication reconciliation process. We found that some important information was not recorded during the medication reconciliation process at each of the five hospitals we visited, and that some hospitals do not report their compliance rate because they have outdated computer systems that do not allow them to track the compliance rate. Three of the hospitals report their compliance rate to Health Quality Ontario and two do not. The compliance rates at discharge for the three reporting hospitals were 100%, 95% and only 20%.

In our follow-up, we found that as part of the annual Quality Improvement Plan's (QIPs) process, the Ministry of Health and Ontario Health discussed the inclusion of new QIP indicators for hospitals. Due

to the COVID-19 pandemic, the QIP program is currently paused so the discussions about QIP indicators have been put on hold. However, once resumed, the Ministry and Ontario Health will discuss the inclusion of a medication safety indicator within hospital QIPs for the 2022-23 fiscal year. The Ministry stated that the estimated completion date for the third action item, which is that, in conjunction with relevant hospitals, to review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed, is contingent upon the Ministry and Ontario Health completing action items one and two.

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.*

  Status: In the process of being implemented by September 2022.

Details

In our 2019 audit, we found that some hospitals do not always comply with policies and best practices for the administration of high-risk medications, such as using an independent double-check to verify medication and dosage; witnessing patients taking and swallowing medications; or confirming the identities of patients. At three hospitals, we observed nine instances where nurses did not comply with medication administration best practices in 15 situations observed. At two hospitals on five occasions, the nurses did not request another nurse to double-check the name and amount of high-risk medication given to the patients. At one hospital, in two instances, the nurse did not wait to witness the patients actually take and swallow their medications. In one of those instances, the medication was a narcotic that could be pocketed in the mouth to be then taken out, stored and used later to overdose. At another hospital, the nurse did not confirm the identification of two patients before administering medications to them.

In our follow-up, we found that all 13 hospitals have policies in place for medication administration processes. More than half of the hospitals have implemented or are in the process of implementing the hospital information system that uses bar code scanning of patients and medications by the nurse, thereby providing additional safety checks when administering medication.

Independent double checks and Two unique IDs:

All 13 of the hospitals provide education to nurses for the independent double-check and patient unique identification processes by providing training through online modules and during nursing medication safety orientation. One hospital monitors nurse compliance using two unique identifiers and the results are shared with staff and senior leadership to identify practice trends and areas to optimize patient safety. This hospital is in the process of establishing a process to ensure nurse compliance with independent double-checks. Another hospital is in the process of developing an audit strategy to assess and improve compliance with medication administration processes by performing regular, for example, every three months, spot audits on independent double-checks and the use of two patient unique identifiers.

Witness patients taking medication:

More than half of the hospitals specifically state in their medication administration policy or through a statement in the hospital information system (HIS), that nurses must witness the patient swallow medication according to practice standards for medication administration. A few hospitals have indicated that they are in the process of explicitly stating this in their medication administration policy. The hospitals that do not explicitly state this in their policy, and

are not in the process of explicitly stating this in their policy, have indicated that reinforcing medication administration procedures occurs through training and other educational opportunities.

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.

Status: In the process of being implemented by June 2022.

Details

In our 2019 audit, we found that six out of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes at the patient's bedside.

In our follow-up, we found that more than half of the hospitals have fully implemented this recommendation and do have a policy in place 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. Three hospitals are in the process of implementing this recommendation, however, some hospitals indicated that due to the COVID-19 pandemic and issues related to resources and restrictions, this implementation was delayed. Another hospital indicated that it had past experience with this approach but achieving widespread sustainability was difficult, however, once its new hospital information system (HIS) is implemented this will be an area for the hospital to re-explore.

One hospital indicated that it will not implement this recommendation because of roadblocks encountered that prohibited continuing this practice, one of which is the collective agreements related to both unions that represent their nursing staff and the lack of overlap in shifts. Additionally, the move to a bedside report meant the nurse stopped writing a shift handover report. It came to light that other disciplines were using the written report and didn't want it to be eliminated. Doing both created a duplication in work for the nursing staff. Another hospital has also indicated that it will not implement this recommendation because discussions at the bedside of a double room leads to privacy breaches. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to recommend that 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.

Hospital Systems for Dispensing Medication Vary from Fully Manual to Fully Automated

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.

Status: Little or no progress.

Details

In our 2019 audit, we found that while all hospitals we visited have controls in place over this process, we noted that hospitals vary widely in the level of automation in this process. We noted that hospitals in Ontario are moving toward automating medication management but are at different stages of implementation, from fully manual to fully automated systems. One hospital we visited was facing a shortage of pharmacy technicians and its pharmacy department operated with manual processes. This hospital informed us that its pharmacy technicians were doing manual tasks that could be automated such as labelling and packaging medication and drawing medication into syringes for a single use. With pharmacy technicians occupied by these tasks, this hospital assigned medication reconciliation

to nurses, who are already busy with patient assignments. Best practice confirms that medication reconciliation can be safely and effectively performed by pharmacy technicians and pharmacists in collaboration with the prescriber. This hospital reported that in 2016, as many as 20% of all reported medication incidents in a month were due to medication reconciliation errors.

In our follow-up, we found that progress has been delayed because of the COVID-19 pandemic. The Ministry is preparing to issue a letter to Ontario hospitals encouraging them to work with their health-care sector partners to consider the cost effectiveness of moving toward the automation of pharmacy-related tasks as part of their annual capital planning process.

Some Hospitals Have Poor Compliance with Infection Prevention Best Practices and Standards

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.

Status: In the process of being implemented by June 2022.

Details

In our 2019 audit, we found that since 2008, as reported by Health Quality Ontario, hospitals have reported improvement in hand hygiene compliance rates. Hand hygiene compliance before patient contact rose from 53.3% in 2008/09 to 89.7% in 2018/19. Hand hygiene compliance after patient contact rose from 69.0% to 92.8% over the same period. Although reported rates have increased over this period, some hospitals have indicated that reported hand hygiene compliance is likely overstated, due to the method used to assess compliance.

In our follow-up, we found that one hospital does use patients to observe and record the hand hygiene compliance of their health-care providers. Some hospitals complete random "blind" audits for hand hygiene compliance and use these observational inspections of handwashing techniques to better identify training gaps, more accurately monitor compliance and provide reminders to staff about the importance of basic infection control. Another hospital has begun to utilize artificial intelligence to monitor hand hygiene in over 500 hospital rooms and is in the process of expanding this to more rooms in 2022. A hospital will explore a process to engage patients and caregivers to observe and record the hand hygiene compliance of their health-care providers to determine whether or not to proceed with such a program. Another hospital is currently considering other methods to assess and monitor hand hygiene and told us that it is a priority on the hospital's 2021-22 quality improvement plan. Some hospitals have not progressed with this recommendation because they are awaiting guidance from the Ontario Hospital Association after the pandemic efforts subside. One hospital stated that its Intensive Care Units have been part of a research study looking at electronic measurement of hand hygiene monitoring, however, this study was compromised by the COVID-19 pandemic and without study results and funding this work will not continue. Some hospitals will not be implementing this recommendation because the main barrier is cost, so there are no current plans to implement this technology and also, having patients observe and record hand hygiene compliance is not something that will be considered at this time. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to 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.

Some Hospital Pharmacies Did Not Fully Comply with Training and Cleaning Standards for Sterile-Rooms

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;*

  Status: In the process of being implemented by December 2021.

Details

In our 2019 audit, we noted that in September 2016, the Ontario College of Pharmacists mandated that by January 1, 2019, hospital pharmacies must be in full compliance with all 50 standards pertaining to the sterile preparation and mixing of intravenous medications. By January 1, 2019, hospitals were supposed to have trained all of their cleaning and disinfecting personnel on how to properly clean sterile-rooms. However, we found that two hospitals we visited had not yet conducted the required training.

In our follow-up, we found that almost all of the hospitals provide their pharmacy and housekeeping staff with training on how to conduct the cleaning, and in addition, the majority of hospitals then test their staff afterwards using theoretical and practical assessments. Another hospital participates in a Shared Service Agreement within their region that provides guidance and oversight to meet the Ontario College of Pharmacists NAPRA standards for the preparation of sterile products (hazardous and non-hazardous). In addition, staff at this hospital are tested using theoretical and practical assessments. One hospital is in the process of ensuring its staff will be recertified yearly through a third-party provider.

- *monitor the cleaning to ensure proper processes are being followed.*

  Status: In the process of being implemented by September 2023.

Details

In our 2019 audit, we visited five hospitals between May and July 2019 and observed that in four hospitals, pharmacy and housekeeping staff did not follow standards and best practices when cleaning sterile-rooms and the equipment used in the preparation of intravenous medications. For example, one hospital was using the wrong cleaning agent to disinfect the equipment. At another hospital, housekeeping staff did not properly gown prior to entering the sterile restricted area, and they cleaned the floors using the same mops used to clean other areas. (Mops should be for restricted use in only the sterile-room.)

In our follow-up, we found that the majority of hospitals have fully implemented this action item by having staff maintain cleaning logs based on the frequency noted in their policy documents and monitored by their certified senior staff. As well, some hospitals perform surface sampling testing to ensure cleaning standards are met. In addition, the effectiveness of the cleaning can be conducted by an external company. One hospital does maintain cleaning logs based on the frequency noted in its policy document with some areas being monitored by their certified senior staff. This hospital plans to implement a formal process of direct observation of staff performing cleaning activities when the new pharmacy department is in operation. Two hospitals are in the process of implementing a quality assurance program to assess whether the cleaning processes are followed according to their policies and procedures.

Inspection Process for Cleaning Reusable Surgical Tools Not Optimal

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.

Status: In the process of being implemented by November 2021.

Details

In our 2019 audit, we found that washing and sterilization of reusable surgical tools and medical devices is the second-highest service area of hospitals' non-compliance with high-priority criteria for patient safety, according to Accreditation Canada. Approximately every four years, as part of its hospital visits, Accreditation Canada reviews the processes hospitals have in place to clean and sterilize reusable surgical tools and equipment. Hospitals' compliance with patient safety best practices or the Canadian Standards Association (CSA) standards in this area is not verified by any other organization. Each hospital is therefore responsible to monitor its own compliance with cleaning and sterilization standards. Some hospitals hire experts to do this work. We compared the expert reports from three hospitals with Accreditation Canada reports and found that the experts identified more instances of non-compliance with Accreditation Canada criteria. We noted that during hospital visits Accreditation Canada assesses hospitals' policies and procedures in many areas, including cleaning and sterilization, but it does not perform detailed checks for compliance with CSA standards.

In our follow-up, we found that more than half of the hospitals have implemented dedicated staff who are responsible for conducting inspections of their surgical tools and medical equipment to meet the CSA standards, in addition to the daily quality testing of the tools and equipment conducted by these hospitals, and the preventative maintenance conducted by the vendors. One hospital has an external company inspect onsite on an annual basis but is in the process of creating a monthly audit tool for internal monitoring to ensure compliance with CSA standards. One hospital that does daily quality testing of the tools and equipment, and preventative maintenance conducted internally and by some equipment vendors, will start to explore costs and options for annual inspections by a third party and then will develop an implementation plan. One hospital that does perform daily quality testing of the tools and equipment, and has preventative maintenance conducted on a quarterly basis by their external vendor, will not implement this additional inspection process because its focus is on the COVID-19 pandemic response. The Office of the Auditor General continues to believe that this is a significant recommendation and continues to recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.

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.*

Status: In the process of being implemented by December 2021.

Details

In our 2019 audit, we found that three hospitals we visited contracted with a third-party provider, SteriPro, for sterilizing medical equipment. The three hospitals did not have processes in place to ensure the contract was managed effectively. Specifically, the lack of key performance indicators prevented the hospitals from reliably assessing the third-party provider's performance.

In our follow-up, we found that three hospitals that contracted with a third-party provider have included the necessary service standards and/or performance indicators in these contracts. One of the three hospitals monitors and reviews the performance indicators on a quarterly basis, in addition, the hospital's senior team reviews compliance on an annual basis and has annual meetings with the third-party

provider executives. One of the three hospitals' senior team meet with the third-party provider regularly to review its performance. One of the three hospitals that uses sterilization services from a third-party provider for one of its programs reports in real-time the defects from its review of products received and any recurring issues to the third-party provider. This was an informal process, however, starting September 1, 2021, this hospital started a process of tracking its product reviews.

One hospital indicated that the renewed contract with the third-party provider now includes a section related to key performance indicators (KPI) and reporting expectations. A KPI dashboard was implemented by September 30, 2021. The KPI dashboard will be reviewed quarterly and revised as required based on feedback and performance. In addition, this hospital indicated that an audit tool is being developed to include a review of contract deliverables such as delivery of service. This audit will be performed annually by the hospital and reviewed with the third-party provider at the annual executive meetings.

Hospital Overcrowding Limits Availability of Beds to Critically Ill Patients

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.

Status: Fully implemented.

Details

In our 2019 audit, according to CritiCall, from April 2016 to the end of March 2019, 784 life-or-limb 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. Some of these patients were denied inter-facility transfer more than once. Ten of these patients died while CritiCall was trying to facilitate inter-facility transfer to another hospital that could provide appropriate care, after at least one hospital had denied the patient's transfer because no beds were available. We found that in the same period about 5,356 non-critically ill patients were denied inter-facility transfers due to a lack of available beds (some multiple times). In August 2019, CritiCall issued a proposal for a province-wide "command centre" initiative, which would collect and analyze, in real-time, the patient bed flow of each acute-care hospital in Ontario.

In our follow-up, we found that the Provincial Hospital Resource System (PHRS), housed at CritiCall Ontario, provides up-to-date hospital level information on acute bed occupancy and resource availability in Ontario's acute-care hospitals. The PHRS Repatriation Tool, an electronic tool used by hospitals to initiate and track requests for patient transfer, supports efficient and timely repatriation back to the home hospital. CritiCall is beginning Admission/Discharge/Transfer (ADT) automation of acute-care bed boards and occupancy information from hospitals directly into the PHRS. This near real-time information will further support timely patient transfers by allowing speedy and accurate identification of available beds across the province. The Provincial Hospital Resource System (PHRS), combined with ADT feed automation, provides the same information that would be available in a provincial bed command centre. CritiCall Ontario's core services, supported by the PHRS and ADT automation, ensure that patients requiring urgent, emergent and critical care, including those with a life-or-limb-threatened condition, receive timely care from the nearest appropriate facility. With the information available from the PHRS, CritiCall Ontario can accurately identify the closest appropriate hospitals with available beds and, hence, direct patient transfers to these hospitals accordingly. Out of 166 hospital sites currently reporting to the PHRS, 100 are ADT-enabled hospitals. The remaining 66 hospitals reporting to the PHRS are not ADT-enabled. Non-ADT-enabled hospitals are those that

do not have their ADT feed set up for the Critical Care Information System (CCIS) (because they do not have Adult, Maternal Neonatal or Pediatric ICU beds) and will continue to enter all of their bed data manually. These sites are smaller hospitals in the province that would normally not have the throughput that larger sites have.

In 2020, CritiCall Ontario also launched a business intelligence tool, CORD-BI, which generates dashboards based on data reported by hospitals to the PHRS. The CORD-BI dashboards are an effective performance monitoring tool, helping hospitals identify, among other items, potential gaps in their communication or processes (for example, when physicians reported no bed and the appropriate bed type occupancy showed occupancy on the PHRS), as well as capacity issues at the hospital for patients by bed type.

To support Ontario's COVID-19 pandemic response, CritiCall Ontario became the single point of contact for all Incident Management System (IMS) transfers in Ontario, working closely with Ontario Health, the Ontario COVID-19 Critical Care Command Centre, regional IMS tables and hospital partners. CritiCall Ontario developed the Ontario Patient Transfer System, which combines data from the PHRS Repatriation Tool with data from ORNGE and Ontario's Central Ambulance Communications Centres, to enable all partners involved in IMS patient transfers to co-ordinate and track planning efforts and patient movement in near real-time.