Office of the Auditor General of Ontario
Bureau de la vérificatrice générale de l'Ontario

News Release

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Patient Safety Culture Should be Given Higher Priority in Some Hospitals: Auditor General

(TORONTO) Most patients in Ontario's acute-care hospitals never suffer harm during treatment, but patient safety does not always get highest priority in hospitals, according to staff, Auditor General Bonnie Lysyk says in her *2019 Annual Report*, tabled today in the Legislative Assembly.

"Each year, Ontario hospitals discharge 1 million people," Lysyk said after her Report was tabled. "Of those, about 67,000 people were harmed during their hospital stay. More needs to be done to bring that number down.

The Report found that surveys of staff at different Ontario hospitals between 2014 and 2019 show that perceptions of patient safety varies significantly, from excellent to poor and failing. 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."

The Report also found that while hospitals have effective processes in place to investigate and learn from patient-safety incidents, the Ministry of Health and hospitals were not doing all they could to further minimize patient harm.

Among the significant findings of the audit:

- Nurses who have been repeatedly terminated or banned by hospitals for lacking competence and/or having practice issues are rehired by other hospitals and continue to pose risk to patient safety.
- Health Quality Ontario and the Canadian Patient Safety Institute have identified 15 preventable patient-safety events that should never happen (called "never-events") that could cause serious harm or death—for example, a foreign object left in a patient after surgery. The Report found that since 2015, 10 out of the 15 never-events have occurred a total of 214 times at six of the 13 hospitals that the auditors reviewed—but none of the six hospitals set any targets in their plans for improvement to stop these events from happening again.
- Hospital-acquired infections such as *C. difficile* are commonly spread by health-care workers through touch. One hospital estimated that patients who acquired *C. difficile* while in its care required additional treatment costing an average of $9,000 each, or $1.6 million overall. In the past five years, 12,208 hospital-acquired *C. difficile* infections were reported in Ontario, suggesting the additional treatment costs as a result of these infections are substantial.

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- Disciplining physicians is costly for hospitals and can take years. For instance, the disciplining of one physician found by a hospital to have practice issues took about four years and cost the hospital over $560,000. An ongoing disciplinary process against this same physician at a second and third hospital, where the physician currently works, has so far cost the two hospitals over $1 million. Physicians' legal costs in such cases are effectively paid by taxpayers because the government reimburses physicians for their malpractice insurance fees. This means physicians can potentially draw out disciplinary cases for years at little cost to them personally.

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