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

Volume 1, Chapter 3.01—Acute-Care Hospital Patient Safety and Drug Administration

2019 Value-for-Money Audit

Why We Did This Audit

- Each year, among the more than 1 million patient discharges from Ontario hospitals, approximately 67,000 patients were harmed during their hospital stay. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital.
- This is the second-highest rate of hospital patient harm in Canada, after Nova Scotia.

Why It Matters

- Ontarians expect to receive safe hospital care.
- Public concern with the safety of health care has increased in recent years due to growing research on the impact that medical errors and other hospital-acquired harm have on patients and on the health-care system.

What We Found

- The vast majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals we visited are committed to patient safety.
- Patient safety culture at different hospitals varies significantly, from excellent to poor and failing. The most recent staff survey results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, show 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."
- Nurses who have been repeatedly terminated or banned by hospitals for lacking competence and/or having practice issues are rehired by other hospitals and/or agencies and continue to pose a risk to patient safety, as hospitals may not share relevant information about a nurse's complete and truthful employment and performance history, with other potential employers.
- Current laws in Ontario make it difficult and costly for hospitals to discipline or terminate physicians whom they find to have competency and/or practice concerns. For instance, separate disciplinary proceedings against one particular physician has cost three hospitals over $1.5 million combined. In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers of Ontario.
- Patient safety "never-events" should, as described, never happen. For example, a foreign object should never be left inside a patient during a surgery. These events, which could cause serious patient harm or death, are preventable and should never occur in hospitals. At six of the 13 hospitals we visited that track such incidents, never-events have occurred a total of 214 times since 2015. Ontario hospitals are not required to report never-events to the Ministry.
- Hospital-acquired infections such as C. difficile are most commonly spread via the hands of health-care workers. Patients who acquired C. difficile while in hospital required additional treatment costing an average of $9,000 per patient. Although reported hand-washing compliance by hospital staff shows improvement, two hospital studies show that these results are overstated. For example, one study showed that staff wash their hands 2.5 times more often when they were observed by an inspector.
- The most recent Accreditation Canada hospital reports show that 18 hospitals did not comply with five or more required practices, such as performing medication reconciliation for their patients. These practices are central to quality care and patient safety.
- Six of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes, such as involving patients, and three hospitals we visited did not always comply with best practices, such as an independent double-check, for the administration of high-risk medications.

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Conclusions

- The hospitals we visited have effective processes in place to investigate and learn from patient safety incidents. However, the Ministry of Health and hospitals can still do more to improve patient safety as hospitals do not always comply with required patient safety practices and standards.
- Hospitals and nursing agencies are not readily sharing information with each other on the poor performance of nurses, which increases the risk that patients can be harmed.

Read the audit report at www.auditor.on.ca