Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

LARGE COMMUNITY HOSPITAL OPERATIONS

(SECTION 3.08, 2016 ANNUAL REPORT OF THE OFFICE OF THE AUDITOR GENERAL OF ONTARIO)

2nd Session, 41st Parliament
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Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Dave Levac, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Ernie Hardeman, MPP
Chair of the Committee

Queen's Park
February 2018

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS
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2nd Session, 41st Parliament

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Research Officer

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INTRODUCTION

On April 5, 2017 the Standing Committee on Public Accounts held public hearings on the audit (Section 3.08 of the Auditor General's *2016 Annual Report*) of Large Community Hospital Operations administered by the Ministry of Health and Long-Term Care.

The Committee endorses the Auditor's findings and recommendations, and presents its own findings, views, and recommendations in this report. The Committee requests that the Ministry provide the Clerk of the Committee with written responses to the recommendations within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless otherwise specified.

ACKNOWLEDGEMENTS

The Committee extends its appreciation to officials from the Ministry of Health and Long-Term Care, the Rouge Valley Health System,[1] Trillium Health Partners, and Windsor Regional Hospital. The Committee also acknowledges the assistance provided during the hearings and report-writing deliberations by the Office of the Auditor General, the Clerk of the Committee, and staff in the Legislative Research Service.

BACKGROUND

Ontario's 147 public hospitals include 57 large community hospitals as well as smaller community hospitals, teaching hospitals, rehabilitation and chronic care hospitals, and psychiatric hospitals.

The Ministry of Health and Long-Term Care (Ministry) defines large community hospitals as those with 2,700 or more acute and day-surgery weighted cases in any two of the three prior years. Collectively, Ontario's large community hospitals

- have about 14,990 (48%) of the province's 31,000 hospital beds;
- in 2015/16 recorded 4.3 million emergency room visits; and
- performed 1.07 million surgical procedures.

This audit examined operations at three large community hospitals, each governed by a different Local Health Integration Network (LHIN). Each of these hospitals treats acute patients at two different sites. For a clearer understanding of all large community hospitals, the audit surveyed the 54 other hospitals in this category, and reviewed available aggregated data for all 57 large community hospitals.

[1] Effective December 1, 2016, the Centenary site of the Rouge Valley Health System and the Scarborough Hospital have merged to become Scarborough and Rouge Hospital. The Ajax/Pickering site of Rouge Valley Health System has been integrated into Lakeridge Health.

Legislation

The Province's 14 LHINs administer health care services under the *Local Health System Integration Act, 2006*. LHINs must enter into a Service Accountability Agreement with each hospital in their area that outlines performance and accountability expectations. Under these agreements hospitals are required to balance their budgets each year and it is expected that a hospital's actual expenditures will not exceed its pre-approved budget.

The *Public Hospitals Act* governs operations of public hospitals in Ontario. Hospitals are required to comply with the provisions of the Act governing admission and discharge of patients, communicable disease protocols, and reporting and safeguarding of patient records.

The *Excellent Care for All Act, 2010* requires that hospitals establish annual quality improvement plans and committees, performance-based compensation, and critical incident reporting.

The *Quality of Care Information Protection Act, 2016* (QCIPA) came into force on July 1, 2017. The QCIPA enables health care providers to have protected quality improvement discussions while ensuring that patients and their authorized representatives have access to the facts about a critical incident.

The *Patients First Act*, *2016* eliminates Ontario's 14 Community Care Access Centres and moves responsibility for home care, long-term care, and related programs to the LHINs. The LHINs' expanded mandate includes primary care planning, coordinating patient care, and ensuring that the health system is more integrated and responsive to local needs.

Funding

Funding to the 57 large community hospitals accounted for about $7.89 billion (46%) of the $17 billion in Ministry funding for all public hospitals. The three hospitals in this audit collectively received $1.3 billion (16%) of the $7.89 billion funding to large community hospitals in 2015/16.

The Ministry provides about 80% of hospital funding (directly and indirectly) through the LHINs, and hospitals generate the remaining 20% themselves from other sources, including fundraising, accommodation charges, and parking and other retail charges.

Hospital funding in Ontario has risen from $11.3 billion in 2003/04 to $17.4 billion in 2016/17, a 54% increase.

Health System Funding Reform

The Ministry's funding reform model, launched in 2012, was intended to allocate health care dollars equitably, promote best clinical practices, and keep spending growth to sustainable levels. The model has two key components:

- The **health-based allocation** component estimates health care expenses based on demographics and actual use of health services, with the Ministry adjusting funding to hospitals based on patient demand and population growth.

- The **quality-based procedures** component funds hospitals for the types and number of patients they treat. The Ministry established specific procedures for hospitals to follow in treating patients, based on best practices and efficiency measures, and determined the amount each hospital would receive under this component.

AUDIT OBJECTIVES AND SCOPE

The audit objective was to assess whether large community hospitals, working together with the Ministry of Health and Long-Term Care (Ministry), have effective systems and procedures in place to ensure that

- patients receive timely, high-quality, safe, reliable, and equitable health care services;
- resources are used efficiently; and
- operational effectiveness is measured, assessed, and reported on.

MAIN POINTS OF AUDIT

The audit found various key factors that hinder patient care in hospitals including

- patients waiting too long in emergency rooms;
- operating rooms not fully utilized;
- long surgical wait times putting patients at risk;
- emergency surgical patients not always given priority (competing with elective surgeries for operating room time);
- patients waiting too long for some urgent elective surgeries; and
- the Ministry's year-end confirmation of funding for cancer surgeries is not timely.

The Auditor also noted concerns about patients developing new health problems as a result of their hospital stay, for example:

- Patients discharged from Ontario hospitals have a relatively high incidence of sepsis (a life-threatening infection).
- Alternate-level-of-care patients (no longer requiring hospital care and waiting for a bed in another setting) suffer from relatively high incidences of falls and overmedication.

Ontario patients have relatively high incidences of health problems and risks that could be better managed with better quality-of-care practices. These include

post-operative pulmonary embolism and objects left inside surgical patients. The audit found that Ontario hospitals do not manage or prevent these health problems as well as hospitals outside Ontario. The audit also found that vital life-saving equipment was not adequately maintained.

Other audit findings include:

- Hospital decision-making on patient care has been negatively impacted by the physician appointment and appeal process (a legal process that hospitals are required to follow under the *Public Hospitals Act*).

- As of March 2016, about 4,110 alternate-level-of-care patients were occupying hospital beds even though they no longer needed them. About half of these patients were waiting for long-term care home beds. The Auditor calculated that hospitals could have treated about 37,550 more patients if these alternate-level-of-care patients were not waiting in the hospital. Hospital beds are more expensive than long-term care beds, and the Auditor estimated the additional cost to be $376 million in 2015/16.

- The three hospitals audited

    - did not have adequate controls over access to private patient information;

    - did not have a centralized scheduling system to efficiently track and manage scheduling for all nursing units; and

    - two of the three had not fully evaluated the costs and benefits of using agency nurses versus hiring additional full and/or part-time nursing staff; while the other hospital has conducted a cost/benefit analysis of the use of agency nurses, the agency costs at this hospital have more than tripled in the last four years.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

Significant issues were raised in the audit and before the Committee. The Committee considers the issues below to be of particular importance.

The Ministry noted that in 2016, responding to growth in demand, Ontario invested more than $485 million, or about 2.8% incrementally, in all hospitals to provide better patient access and to reduce wait times for services. As part of the *Excellent Care for All Act, 2010*, hospital funding generally follows the patient receiving care.

In order to address wait times for specialists and specialist services, the Ministry has invested over $2 billion for more than three million additional procedures to help reduce wait times. The Ministry is also collaborating with the LHINs to determine ways to address wait times and risks to patients.

The Committee heard that the primary challenge facing Ontario hospitals is the presence of alternate-level-of-care (ALC) patients who, from a medical perspective, are ready to leave hospital but are unable to immediately return home. These patients may be waiting for placement in long-term care, rehabilitation hospitals, home care, or other community-based facilities. At present, 16% of patients overall in Ontario hospitals are classified as ALC. This situation contributes to emergency room (ER) overcrowding and a risk that surgeries will be cancelled.

For the future, the Ministry is focused on setting the stage for a health care system that is designed to meet the challenges of an aging population with increasingly complex health care needs.

Funding decisions

The Auditor noted that the Ministry's timing of funding decisions, particularly for cancer surgeries, has made it difficult for hospitals to properly plan their operating budgets throughout the year.

The Ministry explained that Health System Funding Reform has created funding streams that follow the patient and reallocates funding among hospitals based on best available evidence and best practices, needs of the population served, services delivered, number of patients, and efficiency relative to peer hospitals. The Ministry continues to collaborate with the LHINs and hospitals to align capacity and funding that is responsive to patient needs.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

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 enables hospitals to deliver surgeries when needed.**

Emergency room wait times

The Auditor found that many patients had to remain in the ER after being seen by a physician because beds in intensive care units (ICUs) and other acute-care wards were unavailable.

The Committee heard that the Ministry has supported improvements in emergency department wait times despite significant growth in demand for emergency department services. Since April 2008, an additional 125,000 patients are visiting emergency departments annually (a 21% increase). During this same period, however, overall emergency department length of stay decreased by 4.8%, from 9.4 hours to 9 hours (the maximum amount of time that nine out of 10 patients spend in the emergency department receiving care or waiting for admission to a hospital bed), with 92% of low-acuity patients (who do not tend to need admission to a hospital bed) receiving care and departing within the four-hour standard.

The audited hospitals noted that alternate-level-of-care patients are a key contributor to the long wait times experienced by patients waiting to be seen in the emergency room or waiting for a bed.

The Committee expressed concern about long wait times experienced by patients at some Ontario hospitals.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

2. **Ontario hospitals should better ensure timely transfer of patients from the emergency room to an acute-care bed when needed by**

    a) **monitoring the bed-wait time by acute-care wards on an ongoing (e.g., hourly) basis daily;**

    b) **investigating significant delays;**

    c) **developing a crisis response system to better handle difficult cases and periods of high volume; and**

    d) **taking corrective actions as necessary.**

Surgery wait times

The Auditor reviewed a sample of surgical cases between January 2013 and January 2016 at the three hospitals visited, and found that delays in emergency surgeries put patients at risk. The leading cause of long surgical wait times is that emergency surgeries have to compete with elective surgeries for operating room time.

The Ministry explained that over 80% of elective surgery patients are treated within publicly reported wait-time targets. In March 2017 the Canadian Institute for Health Information noted that Ontario has the highest percentage of patients (in Canada) achieving wait-time targets for elective surgical procedures, and the lowest 90th percentile wait times for diagnostic procedures such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans.

The Committee notes that the Ministry does not collect or monitor emergency surgery wait times, and did not address the Auditor's finding of long emergency surgery wait times in its response to the Committee.

In their response to the Auditor's recommendation, the hospitals audited agreed to review their methods for tracking and analyzing the timelines for emergency surgeries. In conjunction with this review, hospitals will ensure that adequate controls are in place to accurately document reasons for delays. When reviewing wait-time targets versus performance, hospitals will determine whether more operating-room time should be dedicated to emergency surgeries or whether surgeons' schedules need to be revised. They noted that the operational feasibility of revising either operating-room time or surgeons' schedules may

require realignment of the funding model and/or the Ontario Health Insurance Plan's fee schedule for surgeons.

The Committee noted the importance of ensuring the timely treatment of patients requiring emergency surgery.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

3. **Hospitals should ensure the equitable and timely treatment of patients requiring emergency surgery by**

    a) **regularly tracking, assessing, and reporting on the timeliness of emergency surgeries performed;**

    b) **documenting, analyzing, and reporting on the reasons for delays in performing emergency surgery; and**

    c) **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.**

Wait times for urgent elective surgeries

Some elective surgeries, while not emergencies, may still be urgently needed, such as surgeries to remove aggressive cancerous tumours. After reviewing five years of province-wide data, the Auditor found that wait times for elective surgeries vary across the province and have not improved over time. As well, hospitals are struggling to meet the Ministry's wait-time targets for the most urgent elective surgeries.

The Auditor notes that the availability of operating rooms is a factor in the long wait time for some elective surgeries, as is the competition for operating room time between elective and emergency surgeries. The Auditor also heard from hospital survey respondents (including physicians) that funding constraints meant that one or more operating rooms were not in use.

The Committee expressed concern over the Auditor's finding of long wait times for urgent elective surgeries. The Ministry explained that an additional $50 million was invested in 2016/17. Targeting improved access and wait times for hospital services, the funding enabled up to 5,600 additional patients to receive quality-based procedures in Ontario hospitals. In collaboration with the LHINs, the Ministry developed a new funding methodology for hip and knee replacement surgery that will be used to inform future funding for these surgeries and will better align capacity with the demand for services.

The Ministry is working in partnership with Access to Care at Cancer Care Ontario to develop a capacity planning tool for urgent elective surgeries that will

support optimal distribution of funds across LHINs and hospitals to ensure timely access to care.

To help provide care first for patients most in need, specialists assign each patient a priority level of 1 to 4, based on specific criteria. Priority level 1 is emergency patients who are seen immediately and therefore not included in wait time data. For non-emergencies, priority level 2 is the most urgent. Current provincial wait time reporting includes separate wait times performance data for each non-emergency priority level as well as combined data for levels 2, 3, and 4. Different targets have been established for each priority level that can vary for specific procedures. The Ministry explained that separating the performance data by priority levels provides a more accurate view of how long a person can expect to wait and the current performance within targets for hospitals and at a provincial level.

The Committee heard that enhancements will be introduced to provincial wait time reporting, and a new model will be tested that will specify wait times for the priority level with the highest volume of procedures during the reporting period. Evaluations will be undertaken to check whether members of the public are able to understand their expected wait time for a procedure.

The Committee agrees that action must be taken to address wait-times to see specialists and for surgeries. The Committee also noted that in order to make informed decisions, patients need access to clear information.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

4. **The Ministry of Health and Long-Term Care should ensure that patients get urgent elective surgery on a timely basis by**

    a) **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; and**

    b) **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.**

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.**

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

a) implementing a centralized patient referral and assessment system for all types of elective surgeries within each region and between regions;

b) breaking down the wait-time performance data by urgency level for each type of elective surgery on the Ministry's public website; and

c) 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.

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.

Regarding wait times for both urgent and emergency surgeries, the Committee noted the relevance of a recent study conducted at The Ottawa Hospital (reported in the *Canadian Medical Association Journal*, July 10, 2017) investigating the effects of surgical delays on in-hospital mortality, length of stay, and health care costs.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

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.

Surgical-safety performance

The Audit found that Ontario patients have a relatively high incidence of health problems and risks—for example, post-operative pulmonary embolisms (blockage in the lung often caused by a blood clot) and objects left inside surgical patients— that could be more effectively managed with better quality-of-care practices.

The Committee asked about post-operative infection rates and heard that the Ministry is committed to improving quality and patient safety across Ontario hospitals and has established and implemented several requirements to strengthen patient safety, including the mandatory public reporting of patient

safety indicators in hospitals and the strengthening of existing patient safety legislation.

The Ministry noted that the new *Quality of Care Information Protection Act, 2016* includes a number of measures intended to address critical incidents and thereby improve patient safety. In addition, all public hospitals are required to develop, implement, and publicly post annual quality improvement plans. These plans include targets and performance measures and an explanation of how these goals will be met. Hospital administrators are also responsible for establishing systems for analyzing critical incidents and developing system-wide plans to avoid or reduce the risk of similar incidents. The Ministry requires Ontario hospitals to report publicly on 10 patient safety indicators, including hand hygiene compliance, hospital-acquired infection rates, compliance with surgical site infection prevention, and surgical safety checklist compliance.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

9. **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.**

High bed occupancy rates

Research shows that occupancy rates (the percentage of available beds occupied by patients) higher than 85% not only result in longer wait times for acute-care beds but also contribute to higher patient infection rates. The Auditor noted that one reason for high occupancy rates in acute-care wards is the number of hospital beds in Ontario occupied by ALC patients.

The Auditor recommended that to help reduce the time patients have to wait for beds, hospitals should ensure that a sufficient number of cleaning 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.

The Ministry described a number of pilot projects focused on improving patients' timely access to services, increasing function independence (that is, how well and independently a person can carry out the basic activities of daily living), enhancing patient experience and satisfaction, and decreasing length of stay and readmission rates.

The Committee asked about Ministry initiatives to reduce the numbers of ALC patients in acute-care wards. The Ministry explained that 10,000 more long-term-care beds have been added, and thousands more are being redeveloped in order to expand size and increase efficiency. In addition, to reduce pressure on the LHINs with the highest alternate-level-of-care rates, the Ministry is developing a new transitional care model.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

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**

    a) **ensuring that alternate level-of-care patients waiting in hospital are safe and receive the restorative and transitional care they need while they wait; and**

    b) **conducting capacity-planning for senior care and address bed shortages, if any, in long-term care homes.**

11. **Hospitals should help reduce the time that hospital patients must wait for beds after admission, by**

    a) **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;**

    b) **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; and**

    c) **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.**

Impact of physician appointment and appeal process

Physicians and other professional staff at hospitals are appointed directly by the hospital's board. Physicians are given hospital privileges, namely, the right to practice medicine in the hospital and use the hospital's facilities and equipment to treat patients without being employees of the hospital. Physicians are reimbursed by the Ontario Health Insurance Plan for services they provide to hospital patients and wherever else they practice.

The *Public Hospitals Act* (Act) governs important elements of the physician-hospital relationship. Under the Act, physicians may appeal a hospital board decision to the Health Professions Appeal and Review Board.

The Auditor noted instances where hospitals were unable to quickly resolve human resources issues with physicians because of the comprehensive legal process that hospitals are required to follow under the Act. In some cases, the Auditor found, "longstanding disputes over physicians' hospital privileges have consumed considerable hospital administrative and board time that could be better spent on patient care issues."

The Ministry accepted both the Auditor's recommendation to review the physician appointment and appeal process and the recommendation that it should assess the long-term value of hospitals employing, in some cases, physicians as hospital staff. The Ministry is committed to developing processes to understand how these issues may be addressed.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

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*.**

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.**

Scheduling of nurses

The audit notes that labour is hospitals' biggest single expenditure, and that nurses are the majority of hospital staff. The Auditor found that hospitals could be doing more to deploy nurses more efficiently.

The Committee asked about the use of agency nurses, and the use of electronic versus manual scheduling systems. The Ministry noted that hospitals that have not already done so will conduct a cost-benefit analysis of the options for more robust centralized scheduling, and review their current nurse staffing model to ensure resources are in place.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

14. **Hospitals should ensure better use of hospital resources for nursing care by**

    a) **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; and**

    b) **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.**

Personal health information

The audit found that background criminal checks were not consistently done before hiring new employees; computer accounts for former employees were not always closed promptly after their employment ended; unattended computers were not automatically logged off; and there was no process in place to manage USB keys or to prevent employees from using unencrypted USB keys.

In response to the Auditor's recommendation regarding personal health information, hospitals agreed to review and improve their practices around computer account deactivation of terminated employees, automatic system log-offs, and encrypted portable devices. The hospitals will engage the Ontario Hospital Association to develop a province-wide hospital standard for criminal reference checks and will ensure practices are in compliance with this standard.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

15. **Hospitals should ensure the safety of patients and safeguard their personal health information through establishing effective processes to**

    a) **perform criminal record checks before hiring new employees, and periodically update checks for existing staff, especially those who work with children and vulnerable patients;**

    b) **deactivate access to all hospital information systems for anyone no longer employed by the hospital immediately after the employment ends;**

    c) **where appropriate, implement adequate automatic logout functions for computers and any information systems containing patient information;**

    d) **encrypt all portable devices, such as laptops and USB keys, used by hospital staff to access patient information; and**

    e) **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.**

Medical equipment maintenance

The Auditor found that while preventative maintenance on large equipment such as MRI and CT machines was performed regularly by external vendors, hospitals were not keeping accurate and complete preventative maintenance schedules for smaller medical equipment, such as ventilators, that are typically maintained in-house.

In response to the Auditor's recommendation regarding medical equipment maintenance, the hospitals agreed to ensure that the databases for recording preventative maintenance activities are accurate and that preventative maintenance activities, including the performance of preventative maintenance staff, are monitored to ensure they are completed on a timely basis.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

16. 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

a) maintaining a complete inventory of medical equipment, with accurate and up-to-date information on all equipment that requires ongoing preventive maintenance;

b) 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; and

c) monitoring the performance of preventive maintenance staff to ensure equipment is being maintained in accordance with appropriate scheduling.

CONSOLIDATED LIST OF COMMITTEE RECOMMENDATIONS

The Standing Committee on Public Accounts recommends that:

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 enables hospitals to deliver surgeries when needed.**

2. **Ontario hospitals should better ensure timely transfer of patients from the emergency room to an acute-care bed when needed by**

    a) **monitoring the bed-wait time by acute-care wards on an ongoing (e.g., hourly) basis daily;**

    b) **investigating significant delays;**

    c) **developing a crisis response system to better handle difficult cases and periods of high volume; and**

    d) **taking corrective actions as necessary.**

3. **Hospitals should ensure the equitable and timely treatment of patients requiring emergency surgery by**

    a) **regularly tracking, assessing, and reporting on the timeliness of emergency surgeries performed;**

    b) **documenting, analyzing, and reporting on the reasons for delays in performing emergency surgery; and**

    c) **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.**

4. **The Ministry of Health and Long-Term Care should ensure that patients get urgent elective surgery on a timely basis by**

    a) **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; and**

    b) **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.**

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.**

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**

    a) **implementing a centralized patient referral and assessment system for all types of elective surgeries within each region and between regions;**

    b) **breaking down the wait-time performance data by urgency level for each type of elective surgery on the Ministry's public website; and**

    c) **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.**

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.**

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.**

9. **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.**

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**

    a) **ensuring that alternate level-of-care patients waiting in hospital are safe and receive the restorative and transitional care they need while they wait; and**

b) conducting capacity-planning for senior care and address bed shortages, if any, in long-term care homes.

11. Hospitals should help reduce the time that hospital patients must wait for beds after admission by

a) 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;

b) 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; and

c) 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.

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*.

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.

14. Hospitals should ensure better use of hospital resources for nursing care by

a) 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; and

b) 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.

15. Hospitals should ensure the safety of patients and safeguard their personal health information through establishing effective processes to

a) perform criminal record checks before hiring new employees, and periodically update checks for existing staff, especially those who work with children and vulnerable patients;

b) deactivate access to all hospital information systems for anyone no longer employed by the hospital immediately after the employment ends;

c) where appropriate, implement adequate automatic logout functions for computers and any information systems containing patient information;

d) encrypt all portable devices, such as laptops and USB keys, used by hospital staff to access patient information; and

e) 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.

16. 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

a) maintaining a complete inventory of medical equipment, with accurate and up-to-date information on all equipment that requires ongoing preventive maintenance;

b) 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; and

c) monitoring the performance of preventive maintenance staff to ensure equipment is being maintained in accordance with appropriate scheduling.