Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

ACUTE-CARE HOSPITAL PATIENT SAFETY AND DRUG ADMINISTRATION

(SECTION 3.01, 2019 ANNUAL REPORT OF THE OFFICE OF THE AUDITOR GENERAL OF ONTARIO)

2nd Session, 42nd Parliament
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The Honourable Ted Arnott, 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.

Taras Natyshak, MPP
Chair of the Committee

Queen's Park
February 2022

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2nd Session, 42nd Parliament

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1st and 2nd Session, 42nd Parliament

FRANCE GÉLINAS	(October 28, 2019 – October 25, 2021)
DARYL KRAMP	(September 22, 2020 – October 20, 2021)

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INTRODUCTION

On June 2, 2021, the Standing Committee on Public Accounts held public hearings on the audit of Acute-Care Hospital Patient Safety and Drug Administration (*2019 Annual Report of the Auditor General of Ontario*), overseen by the Ministry of Health and Ontario Health.

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, Ontario Health, and the Ontario Hospital Association. 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 Legislative Research.

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.

The Auditor found that while most patients in Ontario's acute-care hospitals never suffer harm during treatment, more could be done to improve patient safety. Data shows that of more than one million patients discharged annually from Ontario's acute-care hospitals, approximately 67,000 were harmed during their hospital stays. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital. The audit 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.

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 follow patient safety standards and best practices developed by several different federal, provincial, and not-for-profit organizations. Some standards and best practices pertain to specific areas of care, such as surgery, or to specific departments within the hospital, such as the hospital pharmacy. Other standards pertain to the hospital as a whole, such as infection prevention and control. There are also legislated requirements that apply to the hospital as a whole.

This audit focused on patient safety in acute-care hospitals, which primarily deliver active short-term treatment. There are a total of 141 public hospitals in Ontario (all members of the Ontario Hospital Association), located across a total of 224 sites. These include 123 acute-care hospitals where patients usually receive short-term treatment; eight chronic care and rehabilitation hospitals for patients with long-term needs; four specialty psychiatric hospitals; and six hospitals that provide a variety of outpatient and rehabilitation services. The audit uses the term “hospitals” to refer only to acute-care hospitals.

2019 Audit Objective and Scope

The objective of the audit was to “assess whether acute-care hospitals achieve patient safety by

- ensuring that staff have processes in place that support the safe and appropriate use of equipment, procedures, and medication in delivering medical care to patients;
- implementing effective processes and systems to identify and reduce the risk of patient harm; and
- identifying, reporting, and responding to incidents of patient harm (including learning from past incidents and taking steps to prevent them from recurring).”

The audit team visited acute-care hospitals of various sizes in regions across the province, as well as meeting with stakeholders and experts, and reviewing relevant documents.

Main Points of 2019 Audit

The Auditor found that “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.”

The Auditor’s significant findings include:

Patient safety culture

- Patient safety culture at different hospitals varies significantly, from excellent to poor and failing. Patient safety “never-events” (preventable incidents that could cause serious patient harm or death) have occurred at six of the hospitals visited by the Auditor.
- At six of the 13 hospitals visited by the Auditor 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 of Health.)
- The most recent Accreditation Canada hospital reports show that 18 hospitals did not comply with five or more required practices that are central to quality care and patient safety.

Nurses

- Current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Limited information about nurses is available to prospective employers and this restricts the employers' ability to assess past performances.

- 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 employment and performance history with other potential employers.

Physicians

- Hospitals are not able to quickly and cost-effectively terminate physicians whom hospitals have found lack competence and harm patients.

Medication administration

- Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is improving.

- Hospitals do not always follow best practices for medication administration.

- Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

Officials from the Ministry of Health explained that when the provincial state of emergency due to the COVID-19 pandemic was declared on March 17, 2020, the Ontario healthcare sector took unprecedented action to ensure that patient needs continued to be met during a time of uncertainty. Over the following 17 months, Ontario's hospitals enacted extraordinary measures in response to the challenges faced in delivering patient care and balancing critical health human resources supply in a constantly changing environment.

Under the *Emergency Management and Civil Protection Act*, Ministry officials noted, hospitals were provided with directives which authorized them to reduce or delay non-emergent surgeries; create alternate health facilities (such as mobile health units to deliver patient care); provide assistance to long-term care facilities that experienced challenges; transfer ICU and acute care hospital patients to other hospitals; and redeploy hospital staff to other hospitals to address critical human resources challenges.

The Committee heard that the Ministry plays an important oversight role in ensuring that important safeguards are in place to protect patients from harm. The Ministry is committed to working with their healthcare sector partners to mitigate the risks associated with healthcare delivery and has taken important steps to strengthen patient safety in hospitals. Ministry officials noted that medical technologies and treatments are becoming more complex, and patients are presenting with increasingly complex needs.

Ministry officials gave an overview of legislative and regulatory instruments that guide the work of public hospitals. The *Public Hospitals Act* provides a number of tools enabling government to intervene in order to address hospital patient safety and quality issues, including setting out requirements regarding reviews and analyses of critical incidents and disclosures to the hospital's medical advisory committee. Under the Act, hospitals are required to publicly disclose information concerning quality of care indicators.

The *Excellent Care for All Act*, 2010, requires all public hospitals to establish quality committees to investigate and report on quality issues, publish annual quality improvement plans, and link executive compensation to the achievement of quality improvement targets. Hospitals are required to identify quality improvement plan priority indicators and to have patient relations processes for receiving, reviewing and responding to complaints from patients and their caregivers

The *Quality of Care Information Protection* Act, 2016 enables care providers to have protected quality improvement discussions while helping to improve patient safety and ensuring that patients and their authorized representatives have access to the facts around critical incidents.

Ministry officials explained that Ontario Health also publicly reports health system data including safety indicators for long-term care, acute care, home care, and primary care at the facility and provincial level.

The Committee heard that hospitals are independently governed by their boards of directors, who play a leadership role in identifying organizational priorities and developing preventive programs to enhance patient safety. Dedicated board committees monitor quality and performance, and provide oversight of quality improvements. Hospitals work very closely with Accreditation Canada and others including Ontario Health to implement best practices.

The Ministry supports the Ontario Surgical Quality Improvement Network which uses clinical data from the 700 hospitals affiliated to the American College of Surgeons National Surgical Quality Improvement Network to inform improvements in care. There are 46 Ontario hospital sites participating, representing 72% of all surgeries performed in the province. Ontario hospitals that participate in this program report better outcomes, shorter patient hospital stays, and fewer surgical complications.

The Committee heard that the Ministry is committed to working with stakeholders to fully implement the balance of the Auditor's recommendations.

Patient Safety Culture

The Auditor reported that patient safety culture at different hospitals varies significantly, from excellent to poor and failing. Patient safety never-events have occurred at six of the hospitals visited by the Auditor but Ontario hospitals are not required to report never-events to the Ministry of Health.

The Auditor found that between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices and standards. For example, washing and sterilization of reusable surgical tools and medical devices is an area where hospitals did not fully meet a significant number of high-priority criteria for infection prevention.

The Committee asked why there is no mandatory reporting of never-events to the Ministry, whether the Ministry is taking steps to track never-events, and what measures are being implemented to reduce the occurrence of never-events to zero. Ontario Health officials noted that never-events are typically a failure of multiple systems, and they intend to follow the Auditor General's recommendations in this regard.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

1. **To further emphasize patient safety as a foundation for hospitals' organizational culture, hospitals should 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.**

2. **To determine and reduce the impact of never-events on patient safety and the healthcare system, the Ministry of Health should**

    a) **work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data;**

    b) **upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the healthcare system; and**

    c) **partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent never-events from happening.**

3. **To minimize the occurrence of serious preventable patient safety incidents, hospitals should**

    a) **enhance patient safety practices to eliminate the occurrence of never-events;**

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

    c) **track and report the number and types of never-events to the Ministry of Health and make the reports public.**

4. **To better enable hospitals to prevent similar patient safety incidents, including never-events, from recurring at different hospitals, the Ministry of Health should 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, or include such knowledge and lessons in an existing forum.**

Nurses and Patient Safety

About 74,000 nurses work in acute-care hospitals, comprising the largest single component of hospital staff, and providing hands-on care to patients at their bedside. Most nurses are employees of the hospital. However, hospitals may also recruit additional temporary nurses from external agencies. These nurses are not employees of the hospital. (About 4,600 nurses were employed via nursing agencies in 2017. Nursing agencies are unregulated.)

The Auditor reported that current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Non-disclosure arrangements negotiated with hospitals by unions, along with concerns about potential civil legal actions, can result in potential new employers not being made aware of a nurse's poor past performance. The audit found that "such practices can mislead hiring hospitals and pose an increased risk to patient safety."

The Auditor noted that Canada (unlike the United States) has no centralized system to which all provincial nursing regulatory bodies can report their disciplinary actions. The Auditor recommended that Ontario hospitals consult a US public database.

The Committee asked the Ministry about the Auditor's finding that nurses identified as incompetent continued to be employed in hospitals. The Committee asked what the Ministry is doing to ensure that prospective employers obtain more complete records of nurses' employment history and performance, and how the Ministry and regulatory college are ensuring that the information is complete and up-to-date.

Ministry officials described a number of steps that have been taken. The College of Nurses of Ontario now reports to a prospective employer on all of a nurse's current employers and provides a history of employers over the previous three years. This information is also recorded on the College's public register. The College of Nurses of Ontario has partnered with nurse employers to establish an employer reference group that will identify areas to support employers' needs related to nursing regulation.

The College of Nurses of Ontario and other Canadian regulators have committed to implementing a national database for sharing nurse registration and discipline information across jurisdictions. Nursys Canada is a national project under the joint leadership of the BC College of Nurses and Midwives, and the College of Nurses of Ontario. They have also partnered with the National Council of State Boards of Nursing (a US-based international organization) to develop an electronic repository for Canadian nurse registration and discipline information.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

5. **To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, the Ministry of Health and the Ontario Hospital Association should continue to work with the College of Nurses of Ontario and other regulatory stakeholders to**

    a) **identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and**

    b) **take steps to address gaps identified.**

6. **In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, hospitals should**

    a) **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; and**

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

7. **To help ensure that when hospitals hire nurses, they have access to the nurses' full disciplinary record, the Ministry of Health should request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to**

    a) **explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and**

    b) **put in place an effective process for background checks on nurses' past employment and disciplinary records from other jurisdictions, including the United States.**

8. **To better inform employers in their hiring decisions and protect patients from the risk of harm, the Ministry of Health should assess for applicability in Ontario the actions taken by US states to protect hospitals and other healthcare 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.**

9. **In the interest of patient safety and in order for hospitals and agencies to be fully aware of a prospective nurse employee's past employment and performance history, the Ministry of Health should explore means to**

a) **enable hospitals and agencies to provide and receive complete and accurate references and information to make informed nursing hiring decisions;**

b) **require these organizations to disclose such information when it is requested by a prospective employer; and**

c) **regulate agencies that recruit nurses.**

10. **In order for hospitals to make optimally informed hiring and staffing decisions, the Ministry of Health should require all hospitals in Ontario to**

    a) **continue to perform criminal record checks before hiring nurses and other healthcare employees; and**

    b) **consider periodically updating checks for existing staff.**

Physicians and Patient Safety

There are about 37,000 physicians in Ontario. Practicing physicians must be members of the College of Physicians and Surgeons of Ontario, which regulates the practice of medicine to protect and serve the public interest.

The *Public Hospitals Act*, *1990*, governs important elements of the relationship between hospitals and physicians, and requires a comprehensive legal process for hospitals to resolve human resources issues with physicians. The Auditor reports that this makes it "difficult and costly for hospitals to discipline or terminate physicians whom they find to have competency and/or practice concerns." The Auditor explains that in defending themselves, physicians "mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers of Ontario" through a liability insurance reimbursement program.

The Committee asked what measures the Ministry is taking to ensure that professional misconduct by physicians is responded to in a cost-effective way. Ministry officials explained that there is ongoing work underway with regulatory colleges to ensure the timely and effective prosecution of disciplinary matters.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

11. **To enable hospitals to take timely action to improve patient safety, the Ministry of Health should ensure that it is 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.**

Patient Safety Practices

The Auditor obtained the most recent Accreditation Canada report from 114 acute-care hospitals and found that between 2014 and 2019, 18 hospitals did not comply with five or more required practices that are important for quality and patient safety. For example, some hospitals did not have strategies in place to help prevent patient falls and pressure injuries; some hospitals did not fully meet a significant number of high-priority criteria for infection prevention. Accreditation Canada found the highest rate of patient safety concerns with medication management and emergency services.

The Committee asked about best practices for oversight to ensure patient safety. They heard that Ontario Health has longstanding capacity from previous work done in evidence-based care at Cancer Care Ontario and the quality standards program at Health Quality Ontario. During the COVID-19 pandemic, Ontario Health directed that capacity towards providing timely guidance on procurements and extended use of personal protective equipment (PPE), among other things. Ontario Health also provided recommendations on how to manage critical care drug shortages early on in the first wave of the pandemic, guidance on infection prevention and control, and clinical guidance for supporting frontline workers in restarting scheduled surgeries and procedures.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

12. To improve patient safety, the Ministry of Health should

a) review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and

b) follow up with hospitals with respect to problem areas to confirm that actions are taken to correct deficiencies.

Medication Administration

The Auditor reported that:

- Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is improving.
- Hospitals do not always follow best practices for medication administration.
- Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.

The Committee heard that in March 2021, Ontario Health released new quality standards focused on medication safety. The standards address patient involvement in decisions about medications; safe and effective prescribing practices; maintaining accurate and up-to-date medication lists; conducting

structured medication reviews; and recognizing, reporting and learning from medication-related patient safety incidents.

The Ministry encourages hospitals—as part of their annual capital planning process—to consider the cost effectiveness of moving towards the automation of some pharmacy-related tasks. The Committee also heard that hospitals regularly review their existing policies and processes for the administration of all medications to make sure that they are following best practices or finding opportunities to improve patient safety.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

13. **Hospitals should reinforce with staff the importance of the medication reconciliation documentation processes in order to reduce the risk to discharged patients, and so that hospitals have all the necessary patient information to properly investigate any medication-related incidents that might occur and trigger hospital readmission.**

14. **To reduce the risk of medication errors and readmissions to hospital, the Ministry of Health should continue to**

    a) **require hospitals to ensure that medication reconciliation is completed for all patients;**

    b) **require hospitals to include medication reconciliation in their Quality Improvement Plans as needed; and**

    c) **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.**

15. **To improve patient safety, hospitals should reinforce with nurses necessary medication administration processes to ensure that**

    a) **independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered;**

    b) **nurses witness patients taking and swallowing high-risk medications; and**

    c) **nurses use two unique identifiers to confirm the identity of patients before administering medication to them.**

16. **To minimize patient safety incidents due to missing information or miscommunication, hospitals should 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.**

17. **To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, the Ministry should work with hospitals toward the automation of pharmacy-related tasks, if feasible.**

Infection Prevention

The Auditor noted that when cleaning and sterilizing reusable surgical tools and medical equipment between uses, hospitals are required to follow standards developed by the Canadian Standards Association and Manufacturer's Instructions for Use. Proper washing and sterilization of surgical tools and medical equipment ensures that they can be safely reused on other patients.

However, the Auditor reported that between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices and standards. For example, the inspection process for cleaning reusable surgical tools is not optimal (improper cleaning of reusable surgical tools can delay surgeries and impact patients).

In addition:

- hospital staff may not be washing their hands as frequently as reported, which contributes to the spread of hospital-acquired infections among patients;

- some hospital pharmacies did not fully comply with training and cleaning standards for sterile-rooms (where intravenous medications are prepared and mixed); and

- hospital pharmacies do not always fully comply with standards pertaining to the sterile preparation and mixing of hazardous (chemotherapy) and non-hazardous intravenous medications.

The Auditor also found that there are significant additional costs to the provincial healthcare system to treat patients for hospital-acquired infections. The Committee asked about the Auditor's finding that two hospitals were rebuilt without having in-house sterilization capacity. Ministry officials explained that this decision was likely made due to capital planning considerations.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

18. **To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, the Ontario Hospital Association should work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as asking patients to observe and record the hand hygiene compliance of their healthcare providers.**

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

a) provide their pharmacy and housekeeping staff, including contracted staff, with proper training on how to conduct the cleaning; and

b) monitor the cleaning to ensure proper processes are being followed.

20. To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, hospitals should have their washing and sterilization of surgical tools and medical equipment—whether conducted in-house or by contracted providers—inspected internally on an annual basis.

21. In order for contracts with private providers of sterilization services to be managed effectively by hospitals, hospitals should

a) include all the necessary service standards and performance indicators in these contracts; and

b) on a regular basis, assess the private service provider's compliance with all contract terms.

Hospital Overcrowding

The Auditor noted that critically-ill patients depend on receiving timely and appropriate care. However, according to CritiCall (a Ministry-funded 24-hour emergency referral service used by physicians dealing with critically ill patients), from April 2016 to the end of March 2019, 784 critically-ill 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.

In recent years, some hospitals, such as Humber River Hospital, have created hospital-based command centres that manage beds more efficiently, thereby reducing patient wait times for hospital beds. In August 2019, CritiCall proposed the creation of a province-wide "command centre" initiative that would collect and analyze, in real time, the patient bed flow of each acute-care hospital in Ontario.

The Committee noted the Auditor's finding that hospital overcrowding limited the transfer of critically ill patients and asked what steps the Ministry is taking to deal with overcrowding. The Ministry noted that it is essential to build capacity in the long-term-care and home care sectors, and to hold onto some of the additional hospital capacity created because of the pandemic.

Ontario Health noted that during the pandemic, CritiCall, local Emergency Medical Services (EMS) and Ornge air ambulance service worked together to create a single transport system to oversee where patients are being moved throughout the province. This coordination made a big difference and Ontario Health is very committed to keeping this in place.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

22. **So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, the Ministry of Health should leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.**

23. **The Ministry of Health should ensure that annual funding to hospitals is sufficient to address chronic overcrowding.**

CONSOLIDATED LIST OF COMMITTEE RECOMMENDATIONS

The Standing Committee on Public Accounts recommends that:

1. **To further emphasize patient safety as a foundation for hospitals' organizational culture, hospitals should 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.**

2. **To determine and reduce the impact of never-events on patient safety and the healthcare system, the Ministry of Health should**

    a) **work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data;**

    b) **upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the healthcare system; and**

    c) **partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent never-events from happening.**

3. **To minimize the occurrence of serious preventable patient safety incidents, hospitals should**

    a) **enhance patient safety practices to eliminate the occurrence of never-events;**

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

    c) **track and report the number and types of never-events to the Ministry of Health and make the reports public.**

4. **To better enable hospitals to prevent similar patient safety incidents, including never-events, from recurring at different hospitals, the Ministry of Health should 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, or include such knowledge and lessons in an existing forum.**

5. **To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, the Ministry of Health and the Ontario Hospital Association should continue to work with the College of Nurses of Ontario and other regulatory stakeholders to**

a) **identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and**

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   a) **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; and**

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7. **To help ensure that when hospitals hire nurses, they have access to the nurses' full disciplinary record, the Ministry of Health should request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to**

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8. **To better inform employers in their hiring decisions and protect patients from the risk of harm, the Ministry of Health should assess for applicability in Ontario the actions taken by US states to protect hospitals and other healthcare 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.**

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10. In order for hospitals to make optimally informed hiring and staffing decisions, the Ministry of Health should require all hospitals in Ontario to

a) continue to perform criminal record checks before hiring nurses and other healthcare employees; and

b) consider periodically updating checks for existing staff.

11. To enable hospitals to take timely action to improve patient safety, the Ministry of Health should ensure that it is 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.

12. To improve patient safety, the Ministry of Health should

a) review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and

b) follow up with hospitals with respect to problem areas to confirm that actions are taken to correct deficiencies.

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14. To reduce the risk of medication errors and readmissions to hospital, the Ministry of Health should continue to

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17. To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, the Ministry should work with hospitals toward the automation of pharmacy-related tasks, if feasible.

18. To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, the Ontario Hospital Association should work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as asking patients to observe and record the hand hygiene compliance of their healthcare providers.

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

a) provide their pharmacy and housekeeping staff, including contracted staff, with proper training on how to conduct the cleaning; and

b) monitor the cleaning to ensure proper processes are being followed.

20. To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, hospitals should have their washing and sterilization of surgical tools and medical equipment—whether conducted in-house or by contracted providers—inspected internally on an annual basis.

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centres" and work with CritiCall toward the development of a provincial bed command centre.

23. The Ministry of Health should ensure that annual funding to hospitals is sufficient to address chronic overcrowding.