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Mercredi 29 octobre 2008

Standing Committee on Public Accounts

Special Report,
Auditor General

Comité permanent des comptes publics

Rapport spécial,
vérificateur général

Chair: Norman W. Sterling
Clerk: Katch Koch

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 29 October 2008

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The committee met at 1233 in committee room 1, following a closed session.

SPECIAL REPORT, AUDITOR GENERAL

Consideration of prevention and control of hospital-acquired infections.

The Chair (Mr. Norman W. Sterling): Good afternoon, ladies and gentlemen. My name is Norman Sterling, and I am the Chair of the Standing Committee on Public Accounts of Ontario.

Just before we get started, I noticed our member John Yakabuski talking to Dr. Jack Kitts from the Ottawa Hospital. I just want to tell you a little short story to begin the hearing here. Evidently there were six Kitts brothers who come from Barry's Bay. How many brothers were there in your clan?

Mr. John Yakabuski: Ten.

The Chair (Mr. Norman W. Sterling): Ten Yakabuskis. So at any point in time, the Yakabuskis and the Kitts could get up a baseball game, a hockey game, a football game or any kind of game at all.

I was talking to Jack: "Who usually won?" He says, "Well, you know, sometimes we won, sometimes they won, but one thing was for sure. At the end of the game there was always a fight." I said, "Oh," and he says, "Yeah. Not a fight between the Kitts and the Yakabuskis but a fight between the Yakabuskis and the Yakabuskis."

Mr. John Yakabuski: We wanted to ensure that the Yakabuskis would win the fight.

The Chair (Mr. Norman W. Sterling): Anyway, on behalf of the committee, I want to thank all of the people for making the effort to come to this committee. The committee, this morning, from 9:30 to 10:30, reviewed the material prepared by our researchers.

I also want to indicate that this is an unusual hearing of the public accounts committee in that we normally deal with the Auditor General's report, which is produced once a year, usually early in December, and the committee then takes sections from that report and deals with them in the subsequent year. The Auditor General informed the committee that he had been looking at infectious diseases, and in the spring, before we recessed for summer, this committee asked the Auditor General to bring forward his report early—and we want to thank you, Mr. McCarter, for doing that—because we thought it was important for the citizens of Ontario to have this report out as soon as possible, and we also decided to have this hearing as soon as we possibly could after the report was put out.

It's the intent of the committee to not only encourage the hospitals that have been audited—there were only three of 150 hospitals audited in Ontario. We want the other 147 to respond to the auditor's report and to our report, which we'll be issuing probably within two months as well.

With that, I'm going to ask the deputy minister, Mr. Sapsford, to make some opening remarks.

Mr. Ron Sapsford: Thank you, Mr. Chairman. Good afternoon to members of the committee. I'm pleased to be here today. On behalf of the Ministry of Health and Long-Term Care, I want to thank the Standing Committee on Public Accounts for providing me with this opportunity to address the Auditor General's 2008 Special Report on Prevention and Control of Hospital-acquired Infections.

Let me state at the outset that the ministry fully supports and appreciates the work of the Auditor General to complete this important special report.

Before I begin to address the specifics of the report, I think it's valuable to review the roles and responsibilities of the various players within the province's health system. Under Ontario legislation, accountability for each entity is clearly set out.

The Ministry of Health and Long-Term Care Act establishes the duties and functions of the minister and, through him or her, the Ministry of Health and Long-Term Care, to oversee and promote the health and physical and mental well-being of the people of Ontario and to be responsible for the development, coordination and maintenance of comprehensive health services.

This includes a balanced and integrated system of hospitals, long-term-care homes, laboratories, ambulances and other health services and providers in Ontario, engaged in providing timely and equitable access to health services to all residents of Ontario.

For the first time, I note that local health integration networks have been invited by the standing committee, in recognition of their role in the province's health system.

The Local Health System Integration Act has established 14 LHINs across Ontario. They're an important part of the government's plan to transform the health system, to make it more patient-centred, efficient and accountable based on local planning for local needs.

With the introduction of local health integration networks, the Ministry of Health and Long-Term Care has assumed more of a stewardship role, focusing more on providing overall direction and leadership for the province's health care system. The LHINs are responsible for planning, funding and integrating local health service providers.

The Public Hospitals Act of Ontario sets out the responsibilities of the hospital boards of directors, as well as medical advisory committees of the hospital. The board is accountable for the quality of patient care provided in each hospital in the province.

Each of the regulated health professions, including the profession of medicine, is governed by the Regulated Health Professions Act, 1991, and a specific profession act. Under these acts, each of the professions has a college that is the self-regulating body for its members. The colleges are to protect the public through the regulation of practice of the profession and its members.

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Finally, the Health Protection and Promotion Act provides the legislative mandate for boards of health and local medical officers of health. The guiding purpose of the act is to organize and deliver public health programs and services, prevent the spread of disease, and promote and protect the health of Ontarians. Medical officers of health are qualified public health practitioners and are responsible for ensuring local services and compliance with mandatory public health programs in their areas.

Let me now turn to outlining what the Ministry of Health and Long-Term Care has done to help Ontario's health system combat C. difficile and similar infectious diseases.

At the outset, I want to acknowledge the seriousness of hospital-acquired infections. Infections cause complications in care and treatment and in some cases can lead to death. That's why, since 2004, following the SARS outbreak in 2003, the ministry has been continually building capacity in the health system to respond to and address infectious disease in health care settings.

Such complex and comprehensive initiatives could not be accomplished in a matter of days, weeks or even months. It's been the dedicated work of many people over the past four years, and will continue over time as we go forward.

None of our accomplishments would have been possible without the exceptional dedication and hard work of ministry staff, local public health units, hospitals and the international experts we've consulted, so I want to acknowledge their invaluable contributions to this work.

The ministry is taking a three-pronged approach to combatting infections in our hospitals. This entails:

(1) turning expert advice into action;

(2) supporting front-line health care workers; and

(3) establishing strong leadership and clear lines of accountability.

First, the ministry is using expert knowledge to understand the science of infectious disease and to combat its spread. Since 2004, Ontario's Provincial Infectious Diseases Advisory Committee, or PIDAC, which is an advisory group to the chief medical officer of health, has worked in a number of areas with respect to infectious diseases. These include publishing best-practice documents such as:

—a best-practices document for the management of Clostridium difficile in all health care settings;

—a best-practices document on cleaning, disinfection and sterilization in all health care settings;

—a best-practices document for infection prevention and control programs in Ontario; and finally,

—a best-practices document on surveillance of health-care-associated infections in patient and resident populations.

Additionally, in 2007, the government established the Ontario Agency for Health Protection and Promotion as a centre for research, for infectious disease control and prevention, health promotion, chronic disease and injury prevention, as well as environmental health. The agency will provide knowledge and technical support to local public health units, other health care providers and ministry partners. The second area is supporting front-line health care workers in their various roles, to help to prevent the spread of infectious diseases.

One of the most important factors in controlling the spread of infectious diseases in hospitals is proper hand hygiene. To change health care practices, the ministry developed the Just Clean Your Hands program, a multifaceted hand hygiene approach for all Ontario hospitals, which was launched in March of 2008.

The ministry provided hospitals with train-the-trainer sessions, tools, and materials such as educational CD-ROMs, posters, and other visual reminders. All Ontario hospitals attended the training sessions.

The program includes an audit tool to evaluate the program's impact, and a dedicated website provides easy access to information and a place for hospitals to share lessons learned.

Better hand hygiene is not only helping to reduce exposure to infection, but also helps to ensure a safer working environment for health care workers. Hospitals will be required to publicly report on hand hygiene compliance rates for their facilities by April 30, 2009.

Since 2004, the ministry has added 166 infection prevention and control practitioners in hospitals across Ontario, one practitioner for every 100 hospital beds. This represents the best ratio of infection prevention and control practitioners to hospital beds in North America. These health care professionals have specialized expertise in preventing and controlling infection. They work with all hospital departments to prevent health-care-acquired infections through education, surveillance and providing expert consultation. The ministry as well has provided extensive training for these practitioners.

Since 2004, the ministry has also created 14 regional infection control networks across Ontario. The networks are there to assist with coordinating infection prevention and control activities and to promote standardization in

health facilities. They work with infection-control practitioners from across the health care sector, including acute care, public health, community care and long-term-care homes. The objective of the networks is to improve patient and employee safety and increase the quality of patient care by bringing stakeholders together to facilitate access to resources, to align activities and to provide education.

As well, Ontario is creating infection control resource teams to provide rapid on-site assistance with outbreak investigation and management in hospitals. The teams, established through the Ontario Agency for Health Protection and Promotion, will be assembled and deployed to support facilities and local public health units in outbreak situations when the chief medical officer of health determines that a need exists.

The ministry has also developed leading-edge guidelines for the planning, design and construction of new hospitals to improve their ability to prevent the spread of infectious diseases. These new standards on physical design are included in the document called Generic Output Specifications. This will ensure that new hospitals in Ontario are designed to address building-related infection prevention and control issues. For instance, the standards encompass new layouts for clinical spaces so that contamination of hospital equipment is less likely to happen.

Currently, the proposed number of single in-patient medical and surgical rooms is considered by the ministry on a project-by-project basis. However, the ministry is noting a general increase in the proposed percentage of single medical, surgical and oncology rooms in hospital construction. Projects like the Sault Area Hospital, Niagara Health System's new hospital in St. Catharines and the Trillium Health Centre included increases in the percentage of single medical–surgical rooms as a result of discussions between the hospitals and the ministry about the benefits of improvements in infection prevention and control.

Specifically, in the Sault Area Hospital prior to this redesign, the number of private rooms represented 21% of the total, and after redesign, that ratio grew to 45% of the total. In the medical–surgical–oncology units, the ratio is going to be 50%. Niagara Health System's new hospital in St. Catharines' design will provide for 80% of the medical surgical beds to be single accommodation. At the Trillium Health Centre, the new addition increases the percentage of single medical–surgical–oncology beds from 6% to 28% of the hospital's total bed complement.

Finally, the ministry and the Ontario Hospital Association have hosted many educational sessions for hospitals to promote best practice. Among these was one entitled Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings and recent training on infection control. These sorts of sessions will continue to be a priority for the ministry.

The third area: The ministry is establishing clear accountability and ensuring strong leadership in our health system to help prevent the spread of infectious disease. On May 28 of this year, the government announced the patient safety public reporting framework with eight indicators, including the incidence of hospital-acquired CDAD infections—C. difficile-associated disease—as part of a comprehensive plan to create transparency in Ontario facilities. Effective September 26 of this year, all hospitals in the province are required to publicly report on CDAD rates and case counts in their facilities through the ministry's public website.

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Dr. Michael Baker, who is physician-in-chief at the University Health Network, has been appointed executive lead, patient safety, to oversee the patient safety agenda and to build on the initiatives that I've just outlined. As an indication of how highly Dr. Baker's and the work of others is valued internationally, earlier this month he was invited as a plenary speaker at the 25th annual conference of the International Society for Quality in Healthcare in Copenhagen. Unfortunately, he couldn't be here today, given that he's away today.

The patient safety indicators include not only C. difficile-associated disease, but also:

—Methicillin-resistant staphylococcus aureus, or MRSA bacteremia infection rates;

—Vancomycin-resistant enterococci, or VRE bacteremia infection rates;

—hospital standardized mortality ratio;

—rates of ventilator-associated pneumonia in intensive care units;

—rates of central-line infection in intensive care units;

—rates of surgical-site infection; and

—hand hygiene compliance among health care workers.

Hospitals are required to report C. difficile-associated disease outbreaks immediately to their local public health units to give medical officers of health the information they need to monitor and to respond to emergent outbreaks. In turn, the medical officers of health, through an established online process, inform the Ministry of Health of outbreaks.

As recognized by the Auditor General, the Ministry of Health and Long-Term Care has made progress and continues to work on addressing the challenges in controlling infectious diseases like C. difficile in health care settings. The focus of the ministry's work to date has been on building capacity, increasing resources and now on provincial reporting and intervention as needed.

But hospitals and their staff are key to the prevention, management and control of this disease, and standardized hospital-based surveillance is a critical component of that management. The success of infection control is very much dependent on everyone within the hospital and health care system.

But it does not stop at the hospital door. Everybody, including the broader community, has a role to play in keeping patients safe. That includes such things as washing their hands properly when visiting a patient in hospital and upon leaving such a facility.

This work is challenging for everyone involved. Although the ministry and its partners can and must remain vigilant, infectious diseases are a reality in hospitals across the world, and they've shown a remarkable ability to evolve and survive. That's why achieving a hospital system where there is never an infectious outbreak is not something to which I or anyone else can honestly commit. But I do have every confidence that the ministry's efforts, in partnership with Ontario's health care providers, will continue to help combat infectious diseases in health care settings.

Thank you, Chair, for your attention.

The Chair (Mr. Norman W. Sterling): I'll now call on Tom Closson, the president and chief executive officer of the Ontario Hospital Association.

Mr. Tom Closson: Thank you, Mr. Chair, and good afternoon. My name is Tom Closson. I'm the president and CEO of the Ontario Hospital Association. The OHA is a voluntary association that represents all of the 157 not-for-profit hospitals in this province. I have three colleagues here who represent the three hospitals that were subject to the audit: Dr. Kitts, beside me, as you've already heard, is the president and CEO of the Ottawa Hospital. Beside him is Bonnie Adamson, who's the president and CEO of North York General Hospital. We seem to have pushed Karen McCullough off the table here, so maybe we can slide her over and get her a little closer to you, at least. She is the vice-president, acute care, and chief nursing executive for the Windsor Regional Hospital.

I'd like to begin by thanking the members of this committee for inviting the hospital sector to speak and answer questions about the prevention and control of hospital-acquired infections. Ontario hospitals are committed to accountability and transparency, and we welcome these opportunities to speak publicly about our successes and our ongoing efforts to do better when it comes to patient safety, which is the number one priority of every hospital in Ontario.

I'd like to begin my remarks by making four points, all of which I'll expand on during my remarks and later during the question time.

First, although certain hospital-acquired, infection-causing bacteria like C. difficile and MRSA are naturally occurring and will never be eradicated, it is the responsibility of the people who work in hospitals to ensure that any hospital-acquired infections that are brought in from the outside do not spread. Second, by standardizing definitions and promoting public reporting of patient safety indicators, the Ministry of Health and Long-Term Care has given hospitals a powerful tool and a powerful incentive respectively to improve their performance in this area. Third, Ontario hospitals are leaders in adapting evidence-based best practices whenever possible in order to promote the safety of both patients and staff. Fourth, Ontario hospitals are safe places to receive world-class health care, and no Ontarian should hesitate to seek care at any hospital in this province.

I'm going to expand briefly on each of these points. I mentioned a moment ago that certain bacteria are naturally occurring and will never be eradicated. For example, C. difficile is a bacteria that appears and is carried in the colons and intestines of approximately 5% of humans who do not have symptoms. When one of these people is admitted to hospital and begins taking antibiotics, the offsetting normal levels of good bacteria in their intestines and colon can be reduced, which allows C. difficile to grow and produce toxins. This, in turn, causes diarrhea or more serious intestinal conditions, which is when C. difficile leaves the body and enters the hospital environment.

This is just one way that C. difficile can enter the hospital environment. I should note that factors such as patient population and types of surgery offered in any given hospital can also have an effect on the incidence of hospital-acquired infections like C. difficile, varying from one hospital to another.

To be clear, I'm not attempting to deflect the blame from hospitals or health care professionals with respect to the management of hospital-acquired infections. Rather, I'm simply noting that certain bacteria, like C. difficile, are naturally occurring and that these bacteria can be brought into hospitals from the outside world, and because of this there will always be a certain number of cases of C. difficile in Ontario's hospitals. Having said that, it's clearly the responsibility of hospitals to minimize the spread of these bacteria through the hospitals to other patients or, ideally, prevent it altogether.

This leads me to my second point regarding the standardization in the use of data. Prior to the ministry's move to standardize the definitions of certain patient safety indicators, including C. difficile and MRSA, and compel public reporting, which is something that the OHA fully supports and is working closely with the ministry on implementing, there was simply no way to reliably track patient safety performance across the Ontario hospital sector. Although many hospitals were tracking certain indicators internally, there was no standard definition of these indicators, and results from hospital to hospital could often not be compared to one another. We're now moving quickly toward an environment where definitions are standardized across the province and results are available for everyone to see. In the OHA's opinion, this is very positive. The ministry, hospital management, infection control practitioners and researchers will now have regularly reported, standardized data to use in benchmarking performance and determining, on the basis of the data, how to move forward most effectively. Further, because the public will have access to the data, the public reporting will enhance transparency, incent performance improvements and ultimately improve the public's confidence in our hospitals.

My third point was that hospitals are leaders in adopting evidence-based best practices whenever possible in order to promote the safety of both patients and staff. As the Auditor General stated in his report, the audited hospitals are all well aware of the importance of preventing and controlling hospital-acquired infections, and some of their infection-control processes were working very well. The Auditor General, on page 29 of his report,

noted that every audited hospital has specially designated infection-control practitioners, some of whom have accompanied their hospitals' CEOs here today and are sitting behind us. Every audited hospital has formal processes in place to prevent and control hospital-acquired infections—on page 10 of the auditor's report—and every audited hospital promoted good hand hygiene—also on page 10—which is incredibly important to preventing and controlling hospital-acquired infections. All three of the hospitals had procedures in place to promote the judicious use of antibiotics, which would help reduce the inappropriate prescribing of antibiotics, which is on page 26. Every audited hospital identifies patients with a high risk of MRSA and VRE, in accordance with guidelines created by PIDAC, the Provincial Infectious Diseases Advisory Committee, the expert body that provides hospitals and the government with advice about standards and guidelines for infection control. That's on page 17 of his report.

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According to his report, where the Auditor General noted hospitals can improve was primarily, though certainly not exclusively, in the area of auditing adherence to and the effectiveness of the infection-control policies and systems that the hospitals have in place. These were very valuable recommendations and ones that I've encouraged all hospitals to review.

I'd like to spend a few moments here discussing hand hygiene, a key topic in the Auditor General's report. Hospitals have focused a great deal of attention on improving hand hygiene. The Auditor General noted that hospitals should monitor where prevention best practices, such as hand washing, are conducted in accordance with PIDAC's recommendations—he says that on page 24—and that the ministry should include hand hygiene compliance as part of its patient-safety indicator public reporting regime. I should note here that proper hand hygiene compliance is about providers consistently cleaning their hands in the proper ways. To be clear, providers are washing their hands. What we need to ensure, though, is that they're washing them often enough, at the right times and for the correct duration.

On March 5, 2008, the ministry launched the Just Clean Your Hands provincial hand hygiene campaign. This program is aimed at educating providers through train-the-trainer sessions on the importance and proper methods of effective hand hygiene. Ontario hospitals have embraced this program, which will take a total of 13 months to fully implement, which means that it should be fully in place by April 2009. The OHA and the ministry have partnered to deliver regional training sessions, which were attended by every hospital in this province. Just last week, the OHA and the ministry launched a complementary hand hygiene campaign called Clean Hands Protect Lives, which is specifically designed to educate Ontario health care patients about the importance of effective hand hygiene.

The OHA and its members are also committed to learning from each other. In addition to taking steps to implement the recommendations from PIDAC's many best-practices documents, there has been the development and dissemination of the Ministry of Health and Long-Term Care's infection prevention and control core competency education program modules. To date, three have been published, including chain of transmission, routine practices, and hand hygiene; CD copies have been sent to all hospitals.

The OHA has also delivered a variety of video conferences, webcasts and education conferences specifically related to patient safety and infection prevention and control, PIDAC's best practices documents and public reporting of patient safety indicators. These sessions are almost always fully subscribed to, demonstrating the interest and commitment among hospital professionals to learn more about ways to deliver the safest health care possible.

This leads me to my final point. Generally speaking, hospitals have sound infection control models. They're committed to using standardized patient safety data and public reporting to drive improvements. They take the recommendations of trusted third parties, like the Auditor General, and incorporate them into their continuous quality improvement programs. They partner with PIDAC, the ministry and each other to share best practices. These kinds of activities and the commitment of the health care professionals who work in hospitals make the care that hospitals provide safe.

However, we occasionally hear about certain cases where a patient has decided to cancel a procedure because they are afraid of acquiring an infection in hospital, based on an article that they read in the newspaper or a story that they watched on television. Stories like that worry me, but the fact that attention has been raised and the fact we can now debate whether proper infection-specific precautions are being measured and reported shows, in my view, just how far we've come on an important topic in a very short period of time.

Can hospitals do better, particularly with respect to infection control? Of course they can. But they're safe, and the patients who are need of care should, without question, go to a hospital to receive it. Frankly, the risks to patients from avoiding a necessary treatment far outstrip the risk of acquiring a hospital-acquired infection, which is a point that I believe the experts would agree with.

I will end my remarks here. Once again, I would like to thank the members of this committee for the opportunity to address you on this afternoon. I thank the Auditor General and his staff for their report and all the recommendations and assistance that they have provided us with since 2006, when they first started auditing hospitals. We truly appreciate it and I look forward to responding to your questions.

The Chair (Mr. Norman W. Sterling): Thank you, Mr. Closson. I just want to ask, given the three hospitals that were involved, would you like to make a very short remark or would you prefer to wait until questions?

Dr. Jack Kitts: We can make a very short comment. I'd like to say that we at the Ottawa Hospital embrace

this audit. I recall the first time the Auditor General called me. I said, "This may sound strange, but I don't feel nervous. I think this is a really good thing to do," and the report didn't let us down. I think that the standing committee's interest in making our hospitals safer is well appreciated by all of us in the hospital sector.

There's no question that the importance of infection control has risen over the last 10 to 15 years in hospitals, received as a turbo boost post-SARS. I think the most significant progress has been in the regional infection control network area. We share patients, and to have one hospital having good practices and the other one not just never made sense. So we applaud that initiative since SARS.

However, as both Tom and Ron said, there's much, much more to be done. In fact, there's so much more to be done, I'd like to make sure that we don't go off in a lot of different, non-focused areas. We should prioritize, focus, practise best practices and, wherever possible, evidence-based ones, because it's a significant investment in hospital funds.

The Chair (Mr. Norman W. Sterling): Thank you very much, Dr. Kitts. Ms. Adamson?

Ms. Bonnie Adamson: On behalf of North York General, I also want to thank the Auditor General for this report. We agree and strongly support the recommendations.

The whole system has been on a learning journey around improvement for infection prevention and control since SARS. The system has learned, the system has improved, and we thank the government for the investments in all the various expert reports, structures and processes that we have all learned from based on evidence, which is critically important, from around the world.

Patient safety: Although it's important that all the reports are evidence-based and implemented, it's also the accountability at the local level to make the change that's required in the organization. At the front line, at the fingertips of all front-line staff, they have the resources, the education and the support they need from the board, from the administration and the accountability systems in place throughout all the structures so that we can execute the very best care for our patients, the safest care for our patients and the safest environment for our staff.

The Chair (Mr. Norman W. Sterling): Ms. McCullough?

Ms. Karen McCullough: I would echo from Windsor Regional essentially the same comments. Then I think I would add that our organization was quite struck by the timing of the call from the Auditor General. It worked very well for us, because we were in the process of kicking off our patient safety campaign within our organization, one of the key elements of course being hospital-acquired infections. It really provided us with an opportunity to do the things that we knew we needed to do that were the right things to do.

Concentrating on public accountability, our organization, Windsor Regional, started in January to publish on our website, internally and externally to the public, the number of hospital-acquired infections that it was in fact showing. We were also very, very aggressively looking at ways that we could communicate with the public and develop a public relations campaign and a public awareness campaign, so this was very helpful as well.

We really embraced the request for the review. We benefited from it, and I believe that the organization and certainly our region will do the same.

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The Chair (Mr. Norman W. Sterling): Thank you very much. Now we're going to go to questions. Basically, the way questioning works in this committee is that we give a block of time to each of the three political parties, as represented by the New Democratic Party, the Conservative Party, and the Liberal Party, and we rotate around the room and try to keep the time between the parties as equal as possible.

I ask that anyone who comes to the front, is giving an answer and is not sitting at the front, introduce themselves, in responding, for Hansard purposes so that it's recorded as to who is responding.

I would add, as well, if someone who is one of the invited guests would like to add to something, please raise your hand. A long as it doesn't get out of hand, we'll call you forward.

I'm going to start the questioning with the New Democratic Party. France?

M^me^ France Gélinas: Oh, there you go. All right, I'll pick up where you just left off. You talked about a learning journey where there is accountability from the board of directors of your hospital to the administration to the staff, and my first question is: Are your housekeeping staff members of your hospital as employees of your hospital, or do you contract out your housekeeping?

Ms. Karen McCullough: At Windsor Regional they're employees of our hospital.

M^me^ France Gélinas: Okay. Then I would be interested in knowing if, in any of the other two hospitals that were chosen, the housekeeping staff are employees of the hospital or contracted out.

Ms. Bonnie Adamson: They're members of our hospital staff.

Dr. Jack Kitts: At the Ottawa Hospital, we have three sites. At two sites it's contracted out and at the other site they're employees.

M^me^ France Gélinas: Okay. Then I guess my question will go to you and you'll be able to talk to me a little bit about both sides of the equation.

She talked about—and I agree—this having been a learning journey for the hospitals in Ontario and other health care providers in Ontario. I certainly agree with the accountability chain that had been put into place, that making our hospitals safe is the job of the board, of the administration and of the staff.

We have also talked about some of the best practices that have been put into place for cleaning, disinfection and sterilization in all health care settings, put forward by

PIDAC, or you pronounce it—anyway, you know what I mean.

Dr. Jack Kitts: Yes.

M^me^ France Gélinas: How does that work, once those people—I'm talking about the contracted-out housekeeping staff—are not part of the chain, they're not part of your staff? Who receives this training? Who gives it? Who is accountable to make sure that all of the contracted-out staff have been properly trained, etc.?

Dr. Jack Kitts: We don't distinguish in that respect. The hospital puts forward policies, procedures, processes, has training and orientation of the staff. Whether it's actual employees of the hospital or contracted-out, they have to follow the policies, procedures, and training methods of the hospital. So we have that aligned; the manager of housekeeping would know that, and we would have the expectations that it would be done and we'd follow that.

Just to follow up, though, housekeeping is an incredibly important element of this, but the other culture that we're trying to create at the hospital is that cleanliness is everybody's job. You can clean a hospital room once a day, and five minutes later there's infection. You can clean it twice a day, and somewhere in between. So I think we have to focus on more than just the housekeepers, make sure that everybody is committed to a clean and safe environment, and that's a challenge.

M^me^ France Gélinas: Okay. So, if the contractor decides to bring in somebody new because somebody calls in sick—the other one is on maternity leave, and then bereavement, etc.—how would you know that this person replacing on the Sunday night shift, when nobody else could be found, has actually had that training?

Dr. Jack Kitts: We would expect that all staff who are working in the hospital are aware of and comply with the policies, procedures and processes of the hospital. Auditing to see whether it happens is a different story, but we would expect our managers to do some audit processes for compliance. But the expectation is, whether you're an employee of the hospital or not, if you're doing work in the hospital you follow the procedures, policies and practices of the hospital.

M^me^ France Gélinas: So those are your expectations but you have no documented way of showing that it's actually happening?

Dr. Jack Kitts: I'm sure that we would hear from the nurse manager on the ward if the room wasn't cleaned or if the housekeeper didn't show up. I suspect that the managers have processes for auditing compliance with the work protocols. These are large hospitals and I expect that there is a feedback loop through many mechanisms, and not just through housekeeping.

The Chair (Mr. Norman W. Sterling): Mr. Closson, did you want to add to that?

Mr. Tom Closson: Yes, I think that this is an important question. Unions and the NDP have been raising this question a fair bit in the media about whether it is preferable or less preferable to have some employees of the organization or contracted-out housekeeping service. I think it's actually the wrong question. I think the real question is, are the people who are doing the housekeeping adequately trained and are they following the appropriate PIDAC policies related to doing housekeeping? If a hospital has their own staff, we would expect that to happen—that the staff would be appropriately trained. We'd also expect that there's a reasonable amount of auditing, which is, I know, a pretty normal part of management practice in housekeeping to ensure that the policies are followed in terms of how often you do the cleaning and whether you're doing it appropriately. The expectation would be the same if it was a contracted-out service and that would be part of the contract itself—that there would be a process for auditing to ensure that the organization was getting the appropriately trained staff and also that the appropriate policies were being followed to do the actual housekeeping.

It's not a matter of whether they're employees of the hospital or whether they're contracted out. It's a question of whether they're appropriately trained to do their job, whether somebody is managing them and whether somebody is auditing to see whether they're following the appropriate practices. You could have breakdowns in that area whether they were employees of the hospital or not. So we just have to make sure, regardless of which model we use in each and every hospital, that the mechanisms for effective management are in place.

M^me^ France Gélinas: With all due respect, I would beg to differ because I was referring to this learning journey and this accountability chain which starts from the CEO, goes to the administration and goes to the staff. Every time you have a break in that chain, you have a risk to the patient's safety. We clearly have evidence that shows that once you contract out part of the services that are part of that chain, there's a break there and automatically there is a weakness in the chain and there is an issue of patient safety. This is what we're talking about today. I think we all agree that the chain of accountability is something that is important. We are of the opinion that once you have contracted out that service, you actually have a break in that link of that chain and that this is an area that could put patients at risk, which was the reason for—

Mr. Tom Closson: The Ontario hospital's view is that there is no evidence to suggest that one method is preferable to another.

M^me^ France Gélinas: Britain's Royal College of Nursing issued a substantive paper in April that goes exactly contrary to what you've just said. They have seen a drop in standards and a rise in infections directly linked to the hospital that had contracted out their housekeeping services. They attributed it right back, and you said it in your opening statement: that the chain of accountability had been broken. But that was only one of my questions.

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Dr. Jack Kitts: But I would argue that's a failure in good management as opposed to the actual employees being contracted out. That's a failure in management.

M^me^ France Gélinas: It's a weakness in the system. I'll let it go around.

The Chair (Mr. Norman W. Sterling): Mrs. Witmer?

Mrs. Elizabeth Witmer: Thank you very much to all the individuals who are here today to respond to questions and concerns that we have.

I would agree, certainly in recent months, there has been a great and admirable effort in order to make sure that collectively, whether it's the ministry or the hospitals or individual groups, we're doing everything we can to stop the spread of the infections. I want to applaud the people for the actions that they have undertaken.

But my question goes back to when the hospitals were first notified of this new strain of C. difficile, of the NAP1 strain. When were they first notified?

Dr. Jack Kitts: Being from Ottawa, we—

Mrs. Elizabeth Witmer: You know things first, do you, Jack?

Dr. Jack Kitts: Well, no. We had started in Quebec. Kathy Suh, our director of infection control, says that we were probably aware somewhere in 2003.

Mrs. Elizabeth Witmer: Right. But you're not sure if that was because of information you received from across the border? I guess I'm wondering, were the hospitals notified by the Ministry of Health about that new strain?

Mr. Ron Sapsford: It's a question I can't answer. I can certainly find out if there were formal notifications, but I think, as the disease became apparent, certainly first in Quebec, and as it exhibited itself in individual hospitals, it became more common knowledge. I can find out specifically if there was a notice put out by the ministry or the chief medical officer.

Mrs. Elizabeth Witmer: I'd just be interested in getting that information because I guess it deals with how, in moving forward, we make sure that—

Mr. Ron Sapsford: Mr. Chair, Dr. Gardam is here and perhaps he has some information that might be helpful.

Mrs. Elizabeth Witmer: Okay.

Mr. Ron Sapsford: Dr. Michael Gardam is the director of infectious disease prevention and control for Ontario's new public health agency, as well as medical director of the tuberculosis clinic at the University Health Network.

Dr. Michael Gardam: Thanks very much. Part of my answer to this question is the fact that in order to know you have the NAP1 strain, you actually have to do additional testing, what we call molecular fingerprinting, which is not something that your typical hospital lab would be able to do. Typically, these strains would have to go to a centralized laboratory that would do this.

Certainly we know, going back to 2003, that hospitals that were involved with a Health Canada project were getting some of the NAP1 strain. I remember there was also a great deal of media interest around the UHN. Right around April in 2004, I believe, at Princess Margaret we found out a number of our strains were the NAP1 strain. It certainly was known in infection control circles that this strain had been here at least since then. Before that, we don't know because we weren't actually looking for the NAP1 strain.

Mrs. Elizabeth Witmer: So it appears that at no time was there any communication from the Ministry of Health to the hospitals. I guess that's what I'm trying to determine.

Mr. Ron Sapsford: And that's what I can't answer, but I'll endeavour to find out for you.

Mrs. Elizabeth Witmer: Okay. I guess the information that I would like to have is, when did you become aware of this strain, when did you communicate with the hospitals and what direction were they given?

Mr. Ron Sapsford: At that time?

Mrs. Elizabeth Witmer: Yes, at that time.

Mr. Ron Sapsford: Chair, if I could, I'll introduce Dr. Mary Vearncombe, who is the chair of the infection prevention and control committee of PIDAC. As well, she's medical director of infection prevention and control at Sunnybrook Health Sciences.

Dr. Mary Vearncombe: When PIDAC was first formed in 2004, it actually recognized that this was a problem. We were watching our colleagues in Quebec with their outbreak and we knew the results of the Public Health Agency of Canada surveillance that was being done, so we knew it was here. The very first document that the PIDAC infection prevention and control subcommittee produced was a document on prevention and management of Clostridium difficile in health care settings. That was published in 2004, and there was a collaborative video-conferencing education session held with PIDAC, the Ministry of Health and the Ontario Hospital Association to disseminate the best practices to Ontario hospitals in 2004.

Mrs. Elizabeth Witmer: So in 2004, the hospitals would have had all the information they needed in order to deal with it?

Dr. Mary Vearncombe: They had the best-practices document as it existed at that time. We have learned over the last few years—and the document's actually been updated several times since then as new knowledge has come forward. We've had subsequent video conferences for Ontario hospitals, telling them about some of this updated information.

Mrs. Elizabeth Witmer: What were some of the first best practices to be shared with the hospitals? What direction would have been given to them?

Dr. Mary Vearncombe: We would start with the early identification of patients, looking for the syndrome of onset of diarrhea so that that patient can be isolated immediately, not waiting for laboratory tests to come back; getting the lab tests off quickly; ensuring that you're working with a laboratory that has a reasonable turnaround time for those laboratory tests; and hand hygiene, which is obviously a major component of control.

The cleaning practices are extremely important in managing C. difficile. It's a spore-forming organism. It's difficult to get out of the environment once it's introduced into the environment, so there are some very

special cleaning practices necessary. There are also antimicrobial utilization issues associated with controlling Clostridium difficile, which are much harder to get at and a much more long-term project.

Early management of cases would, hopefully, decrease the transmissibility.

Mrs. Elizabeth Witmer: So you're saying that in 2004, hospitals would all have received that information and should have started the practices in order to control the infections?

Dr. Mary Vearncombe: It was available in 2004 as a best-practice document.

Mrs. Elizabeth Witmer: All right. What was the ministry's role, then, Mr. Sapsford? If all this was known in 2004, and we subsequently saw outbreaks, what role did the ministry have in ensuring that not only was the information communicated to the hospitals, but that the hospitals were actually following through? Were they being provided with additional financial resources to do so?

Mr. Ron Sapsford: Well, as I've said before, the work the ministry was pursuing was based on the best-practice guidelines, so that people knew the information—and, when an outbreak occurred, how to control it—as well as the educational resources. So the expectation of the ministry would be that this kind of documentation would be used by hospitals. There was not any specific audit to follow up on compliance with that, if that's part of your question. We did not do formal follow-up.

I suppose the other response the ministry made was, where outbreaks did occur and the ministry was notified, to ensure those hospitals had professional expertise and support in the management of it, in the few cases where there were large outbreaks in fact that did occur.

There has not been any specific financial allocation to support this, but in a couple of cases, the ministry has made additional payments to hospitals that have had outbreaks and that have incurred additional costs in the control of or the response to that. So in three cases, I believe, one-time payments have been made to those hospitals to support them financially.

Mrs. Elizabeth Witmer: So I guess, since 2004, although best practices appear to have been shared, it's pretty well left up to the individual hospitals to determine how they are going to move forward. Obviously, there may have been a breakdown in the communications, because we're certainly hearing from some of the hospitals that they didn't receive any information.

I'd just like to ask each one of the CEOs: When were you first notified there was a problem and what steps were you recommended to take? Maybe we'll start with you, Dr. Kitts.

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Dr. Jack Kitts: Okay, again, because we have probably a higher number of Quebec patients at the Ottawa Hospital, our infection control group made us aware of this problem in the Montreal hospitals well in advance of it being an issue in Ontario. We talked about it, and the best practices described in the document are what I think any leading infection control person would recommend to hospitals. I remember the discussions in 2003 around judicious use of antibiotics and getting the medical staff involved in ensuring that we're doing the best practice there.

The most difficult one was the hospitals that have old facilities. We had—I don't know, in 2003—an opportunity in some of the old wards where four patients were in this room and four patients in that room, and there was a washroom in between. You'll recall the history of the hospital. In 2003 we were trying to come out from a difficult merger, so we made the policy that all new construction would be at two to one—two beds to one bathroom—and that we would retro the rest of it to no more than three to one. In the areas where we had to go to three to one so we didn't lose a whole lot of beds, we increased the housekeeping and the practices. We chose beds that would be considered to be less high-risk, less sick patients.

Those discussions happened in 2003, and again, I'm sure when the ministry paper came out, a lot of hospitals were already doing that or doing their best to do it.

Mrs. Elizabeth Witmer: You made an interesting point. There are some unique challenges to older facilities.

Dr. Jack Kitts: The real discussion, and our infection control people will testify, is this whole notion around hospitals being 100%-plus occupied. If we do the best practice in infection control, I'd love to go to one patient per washroom, which I think is definitely the future, but if we were to take our hospital and go to two to one, even, entirely, we'd lose 100 beds. You have to balance that with how you serve your community with less resources, still balance the safety aspects of it.

Mrs. Elizabeth Witmer: Thank you. Ms. Adamson?

Ms. Bonnie Adamson: When the information came in to the North York General Hospital from the ministry, it went to the experts in infection prevention and control and our policies were immediately updated. Processes and education occurred both with the medical staff advisory group, all the physicians, all the professions, and the administration was certainly aware of it because of the heightened awareness across the system.

At that time, in the context, we were also vigorously working on MRSA, VHE and general infection control. While the content expertise was being documented and appropriately put into policies, procedures and education programs, the emphasis is really on hand washing. There was a concerted effort on hand washing throughout that time and an increased awareness from senior staff to front-line staff about the importance of it. Over the last two or three years, you can really see a huge shift in each person understanding the difference it can make to wash your hands, the appropriate times to wash your hands, the appropriate solutions to use and the dramatic impact it has on infections such as C. difficile. Once it became more evident and apparent in hospitals as they understood from lab tests what exactly was the cause of the

symptoms, then the formal documentation came forward which goes to senior management and the board, and the quality committee of the board reported directly to them on a very regular basis.

Mrs. Elizabeth Witmer: If I go back—and there has been remarkable progress made; I was saying this morning when I visit a hospital now they always point out to me what they're doing in the area of infection control—I'm incredibly impressed. When I go to an annual general meeting, of course, this is now on the agenda of the boards. We've made great strides.

But what would you say is the main difference right now? The impression is that, at first, hospitals were pretty well determining themselves what it is that they should do. Do you feel there's better support today, better communication today in addressing this issue? What's improved?

Ms. Bonnie Adamson: I would say that all of those things have improved, that there is a significant amount of resources for organizations to use, learn, implement and adapt from a variety of provincial resources, national resources, international resources. The best evidence that's available in the world is at our fingertips. We need to take that into the organization and to implement it.

Again, the change in human behaviour is probably the most difficult part of it. The evidence is clear, people understand it objectively, but getting the change in behaviour is the leadership challenge. I think the public is more aware, people are more understanding of the impact of not washing your hands. So with the resources that we've been provided—Just Clean Your Hands and other areas of programming—I think you'll see a shift in the culture in organizations at the front line and increasing compliance rates of the appropriateness and the compliance of hand washing.

Mrs. Elizabeth Witmer: And Ms. McCullough?

Ms. Karen McCullough: I would agree. I think that the single leading factor that's driving change for infection control practices in the province right now is accountability: internal accountability and external accountability. I think I can speak on behalf of most health care workers: Everyone chose to get into health care to do the best job that they can. It's critically important, and not one of us wants to be in a place where we're not utilizing best practices and reporting that accountability internally to our boards and to the public as to how well we're doing and asking ourselves the question, "Is it good enough?" If the answer is, "It's not good enough," what are we doing, how do we go back and how do we change those practices? That's really key. It's awareness and holding ourselves and the public accountable for results.

The Chair (Mr. Norman W. Sterling): Dr. Gardam, did you have something you wanted to add?

Dr. Michael Gardam: Yes, thank you. I just wanted to make a comment, I've worked in the infection control area for the last 10 years, and one thing that has really struck me is how much this field actually has changed over that decade. It used to be very hard to get people's attention to this area, and that has dramatically changed for the better.

The other thing I wanted to just point out is that I've worked with a number of organizations throughout Ontario, helping them with their C. difficile outbreaks, and one thing which will be a huge help to them is now having mandatory public reporting of raids. Because one of the biggest challenges was that hospitals had a sense they were having problems, they were doing the best-practice actions, they were trying a variety of things, but they had nobody to compare to to know, "Are we really an outlier? Is everybody else having the same problem?" I've already seen, over the last two months now with mandatory public reporting, that hospitals are now saying, "Aha. Now I know where we are, and, yes, we do need help." So that has been a huge benefit for us.

Mrs. Elizabeth Witmer: I want to congratulate you for the work that you have done, because I think you've really brought the focus to where it needs to be. You've made a real difference, I think, as far as protecting the public as we move forward.

The Chair (Mr. Norman W. Sterling): I'm now going to go to the Liberal caucus. Mr. Zimmer.

Mr. David Zimmer: We've had quite a discussion about some of the technical aspects of this issue, but I wanted to just bring a perspective from a constituency level or the public. When this issue got out in the media, my constituency phones and visits and so on just sort of lit up for a while, because of course there was this fear: "I'm going to go to the hospital and I'm going to get some terrible disease and die. I don't want to go to the hospital, and if I have to go to the hospital"—you know, there was a lot of fear out there, particularly with senior citizens and perhaps young mothers and so on.

So my question is—and we've heard a lot about public awareness, public education and all of that sort of stuff. I suppose what really put the fear in some members of the public is this idea of hand washing, which is how it came out in the newspapers. I think all of us—I mean, that's one of the things we learned early on, in kindergarten: You wash your hands and you show your fingernails and all that sort of stuff. So I got a lot of calls from members of the public who just had great difficulty getting their head around this problem of infections in the hospital and somehow relating it to hand washing and so on, and how there could be such a gap between one's basic expectations that they picked up in elementary school about hand washing and cleanliness. Then they read these stories that the report showed that it was the physicians themselves that were really having a problem with hand washing. People were calling my office and just scratching their heads; they could not comprehend this.

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So my question is, if the public awareness programs and the public education training leaves gaps or doesn't seem to be taking hold, has there been any thought given to a plan B, if you will, which might include some sort of enforcement provisions or sanctions for folks that aren't doing what they should be doing? What, in this kind of world—and "sanctions" may be too harsh a word. But what sort of sanctions/incentives are out there? Because I

think, in addition to the technical conversation, we should be having a conversation about the degree to which the public's lost some confidence or they've got fear about going to the hospitals. We have to, as politicians—constituency politicians, party politicians—think about restoring that confidence, together with our health care partners. And so these calls to my constituency office—"Mr. Zimmer, they want me to go the hospital and I'm afraid to go," and they're having a major anxiety attack.

Any comment on, if the public awareness stuff doesn't seem to be taking hold, what's the plan B?

Mr. Ron Sapsford: I think the approach that I tried to outline is the approach that certainly the ministry, and I know some of my colleagues, would agree is the best opportunity for success.

So number one: the expertise. What is the disease? You've heard some of the physicians already comment on it being a spore-bearing disease; it's harder to kill; you need to do certain precautionary measures that you might not in another bacterial disease. So what is the expert advice? What are the best practices? The second point is to support front-line health care workers (a) so they know and (b) so they're educated.

The third piece is the accountability piece, which I think you're referring to, particularly on hand hygiene. So the response to that is, we will do public reporting and put it on the website as of April 2009. It's one of public reporting, and I think that all of us would agree that the transparency around public reporting, coupled with the accountability framework that we've talked about—and for hospitals, that is the Public Hospitals Act, the responsibility of board and management. Using the guidelines in the context of the hospital for the hand-washing program is seen to be the best possible way.

I have to admit to you, I'm relying to a degree on the professional responsibility of hospital workers in their professional capacity, and we've heard information today. Health care workers want to do the best possible, and I think, armed with the right information, the expectation of accountability for the performance in this particular area, that the results will be better than average. So the public's concern that you've expressed—we hope that will begin to shift the view of the public to this particular issue.

The Chair (Mr. Norman W. Sterling): Dr. Kitts, did you want to add something?

Dr. Jack Kitts: Just sort of building on what Ron said, back to Ms. Witmer's question: "What is the biggest, most profound thing that's brought infection control to the forefront?" I think it's the admission that patients are not as safe as we once thought they were in our hospitals, and that the actual problem is preventable. However, I'm not sure that boards across the province—I think they're all at very different stages; I think of administrators and so on. I think that if we are going to actually truly change the culture—I mean, the layperson asks, "Why wouldn't the doctors and nurses wash their hands? We do it in kindergarten." I think it comes down to a cultural change. Nobody comes to work in the morning to do harm, but we've evolved in our practice in a way that I think we need to—and I have this discussion with our infection control people. I think the Holy Grail here is to convince the health professionals that by not washing their hands, they really are doing harm. I don't believe, in their heart of hearts, they believe they are. Until you get that culture where they believe they're going to hurt a patient by not washing their hands, we're going to still have to struggle to convince them.

The Chair (Mr. Norman W. Sterling): Okay, I'm going to go on to Mrs. Van Bommel. We've got to keep going here a little bit.

Mrs. Maria Van Bommel: I have a question I think might best be answered by Dr. Gardam. In the auditor's report, he talks about screening and the whole practice of screening at the time of admission. Certainly the PIDAC makes recommendations on how that could proceed. Is there any value or benefit in screening patients at the time of discharge, especially if they are at risk or at high risk of having acquired a hospital infection?

Dr. Michael Gardam: There certainly is in certain circumstances. The concept of screening people when they're being admitted is to find out who has something before they come into your organization so that you can isolate them appropriately so hopefully it doesn't spread. The concept of screening on discharge is to find out if anything has spread to people.

Certainly, discharge surveillance is an option. For example, at the University Health Network, we do that on some of our floors where we have had problems with MRSA and VRE in the past. That is an added cost, it's an added workload issue with the health care workers, but it certainly is something that is done, probably not as universally as admission screening. But it is one of the tools we have to see what's going on within the organizations.

Mrs. Maria Van Bommel: Thank you. I would like to ask the hospitals here: What is your practice at the time of discharge when you're dealing with at-risk or high-risk patients?

Dr. Kathryn Suh: Dr. Kathy Suh. I'm the medical director of infection control at the Ottawa Hospital. We don't routinely perform discharge screening. We will perform discharge screening similar to what Dr. Gardam said if we recognize that there is an issue with a particular unit, where we've had problems with nosocomial transmission. In those instances, we may perform discharge screening, but it is not a routine practice. We focus more on admission screening.

Mrs. Maria Van Bommel: Do you do anything at the time of discharge in terms of informing a patient of things to watch for, symptoms that might indicate they've acquired an infection?

Dr. Kathryn Suh: I think that can be answered in the context of which organism you're talking about. For Clostridium difficile, at our institution we have a patient information sheet that is given to all patients upon discharge that outlines, if they have received antibiotics, the symptoms they should contact their physician for.

That has been available to them for at least a couple of years. For MRSA and for VRE, I think one important thing is that the majority of patients who acquire these organisms don't have symptoms. So if we pick up in hospital that they do have one of these organisms, then there is obviously isolation and education of the patient. But the majority of these individuals will not have symptoms and therefore may not know that they've acquired them.

Interjection: Would you like to hear from us?

Mrs. Maria Van Bommel: Yes, please.

Dr. Kevin Katz: I'm Kevin Katz, the medical director of infection prevention and control at North York General. I agree, for the antibiotic-resistant organisms, with everything my colleagues have said. If there have been transmissions or outbreaks, we will use discharge screening to get a better handle on what's happening.

Just to add to what my colleagues have said, there are certain situations where we will look in the post-discharge period—for example, for surgical-site infections. The definitions include follow-up for 30 days; if you have an implantable device, it will be up to a year. We do extend our surveillance past the discharge period for things like that and we do try to build networks with our partner hospitals that are around us so that if people are discharged from our centre to another facility—if something happens there, we're informed, because it could relate to something that's happened during our admission. Our quality control processes will look back and try to remedy any situations with that knowledge.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Norman W. Sterling): I know there are other people who want to talk on this, but quite frankly, I think we're more concerned, in terms of the auditor's report, about pre-screening rather than post-screening.

I'd like to give it to Mr. McNeely at this point in time.

Mr. Phil McNeely: My question would be for Dr. Kitts. We're very proud of the Ottawa Hospital in our community and we've got the civic campus, the general campus, the heart institute and the rehab centre. You talked a lot about cultural change today, and I'm just wondering if you could comment very briefly on where you are as a hospital in that cultural change, adopting the best practices. Where do you think it is practical to go to? What advice would you give this committee on how we can support what you're doing in the hospitals in Ontario?

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Dr. Jack Kitts: Thanks very much, Mr. McNeely. Probably, like all CEOs in Ontario, we owe it to the infection control leaders, whether coming out of the provincial—PIDAC, with its recommendations—or our own infection control experts. We have Dr. Virginia Roth, who's now on maternity leave, and Dr. Kathy Suh, and there's a whole host of them whom we count on to provide advice. They report directly to the vice-president of medical affairs and quality and safety, who gives a report to every senior management on infection control practices and how we might improve them.

The hospital, as you say, has five different sites or programs, if you will, but we have a corporate infection control policy and a corporate infection control director, so they are not different practices or different cultures on each of the sites vis-à-vis patient safety and infection control.

I guess the advice I would say to this committee is, first, as I said in my opening comments, I applaud raising the visibility and raising the bar, keeping it high-profile. There is a public accountability, as well as a hospital accountability. Keep monitoring and supporting us in terms of changing that culture because it is, at the end of the day, very much a cultural change hard for the lay-people to believe—that you have to create a culture committed to cleanliness and safety in a hospital—but it is. It's going to take time, it's going to take effort and it's going to take committees like this, keeping the profile high.

Mr. Phil McNeely: Thank you.

The Chair (Mr. Norman W. Sterling): Could I just ask a question? We have two executive officers from LHINs here. Is there any role that LHINs are playing in terms of trying to keep continuity across their regions with regard to this particular subject? In other words, if there's an outbreak at the Ottawa Hospital, is the Almonte hospital, which is another one in the same LHIN, being advised, or how is that operating? Perhaps you could introduce yourself.

Mr. Gary Switzer: Gary Switzer, the chief executive officer of Erie St. Clair LHIN. Thank you very much.

With respect to our role in this, through our regional infection control network, it gives us the opportunity to pick up on what Mr. Kitts said earlier. We share patients. It's just not the hospitals; it's the entire system. So we're using the network to take advantage of this from a system perspective with our long-term-care homes, with all our community service agencies and with the CCAC as well.

With respect to information that we receive from a provincial basis, we do have access to that information, and our planning department receives information on occasion when these outbreaks do occur. We are flagged through broadcast e-mails so we have a higher level of awareness. But our key initiative now is working through our regional network to look at it from a system perspective to drive those improvements, and drive those improvements through accountability agreements as well.

Mr. David Zimmer: Is there another LHIN?

The Chair (Mr. Norman W. Sterling): Is there another LHIN?

Mr. Hy Eliasoph: Hy Eliasoph with the Central LHIN in the northern part of the GTA. Bonnie Adamson at North York General is a part of our LHIN.

Just to give you a sense of what it looks like from a system level at the local level with the LHINs, Bonnie will know that next month when the hospital CEOs meet with us at the LHIN, as they regularly do, we have some three items on the agenda pertinent to this subject. One is the Auditor General's report and how we are going to work together as a network of hospitals to support, in-

form and coordinate our efforts. Two, we will be meeting as a group as well, on a related topic, to talk about how we're going to manage and work with the report coming out soon on hospital mortality rates. So we're developing a coordinated strategy to look at how we can support hospitals in sharing information, practices and strategies around how to deal with that. I noticed—not that I was looking at my e-mail today while we were here—that the C. difficile numbers have come out, and the same idea applies: that the LHIN's role, really, because we don't deliver services, is supporting the hospitals and coordinating much of what we heard around sharing and implementation of best practices so that we can spread that across the entire LHIN.

The Chair (Mr. Norman W. Sterling): Thank you. I'm now going to go back to France.

M^me^ France Gélinas: Thank you. It was a bold statement, I think, that Dr. Kitts made when he said that hospitals have come to the realization that they are not as safe as they could be and that it is preventable. Certainly, those are the first steps to improvement and to develop best practices and best opportunities for success and accountability. I think it was you, Ron, who said that the increased transparency with the mandatory reporting will improve public confidence in our hospitals and in the public system.

I would be interested in knowing, from the ministry's point of view, what are the ministry's policies that mandate the hospital to report? In your speech, you talked about hospitals being required to report C. difficile and CDAD outbreaks to the health unit. The medical officer of health reports that to the ministry. Are there any Ministry of Health policies that mandate the hospitals to start public communication? Not only do you let the health unit know that you have an outbreak, but do you have policies so that the hospitals also have to let the public know?

Mr. Ron Sapsford: The stage we're at is for the public reporting of the eight or nine different indicators. The purpose, when there is an outbreak, is to achieve containment and control of it so that the spread is minimized, which is the principal reason for the report to the medical officer: so that the expert resources that are needed can be brought to bear. In terms of a response to an outbreak, that has been seen to be the key related issue.

The tracking of new cases is the public reporting requirement at the moment. So on a monthly basis, any new cases will be reported. There is not a specific requirement in this new policy approach where the hospital must do a public notification, except in as far as the cases are going to be reported each month in follow-up. But notice of an outbreak publicly is not currently on the policy requirement.

I think Dr. Williams may want to add to that.

Dr. David Williams: Dr. David Williams, acting chief medical officer of health. It is reportable to the medical officer of health, and then, depending on the situation, they work in consultation with the team on the risk-assessment management and communication, and where it's necessary—say, if it's a report of an outbreak of two or three cases on one ward, it may not require public notification as long as it is contained and handled that way. But generally, the messaging from the team is that there should be open communication, especially if it has impact on the public or visitors in that context. That is encouraged at each time. Of course, in September we're going to be adding the number of hospitals that have had outbreak reports in the public reporting.

The Chair (Mr. Norman W. Sterling): Mr. Closson, you wanted to—

Mr. Tom Closson: One of the reasons for being of the Ontario Hospital Association is to try to help hospitals understand what best practices there are in other parts of the province and get them to use each others' practices. For us, it's really helpful to have PIDAC there, because they use evidence to figure out what is best practice.

Specifically to the question that was asked, first of all, all hospitals would report outbreaks on their websites, but you have to assume, then, that people go to the websites to find that. Hospitals do, to a varying degree—I doubt if it's highly consistent—put up signs, and also on the phone messages, if you phone into the hospital, that would be the first thing that would come up.

I think probably getting a better degree of standardization in that area probably would be helpful.

1400

Getting back to the earlier comment about the public losing some level of confidence in the health system and being a little afraid to go into hospitals, we do need to be communicating with the public really well about not only what the situation is but also what we're doing about it. Right now the OHA is actually doing a review of all of the hospitals in the province to see the extent to which they're using PIDAC's best practices for infection prevention and control. We're going to understand: If they aren't, what are the barriers? There has been no comprehensive audit in the province of the extent to which each and every one of the 157 hospitals are following those best practices. We're going to find out, and we're going to find out what the barriers are that they see in terms of trying to get the practices in place. As we keep deciding on what are more and more best practices, we need to disseminate them and we need to make sure people are using them.

M^me^ France Gélinas: Relating to my question, I asked the ministry, and the ministry said no, they don't have any policies that direct communication from the hospital to the public. You've mentioned that many of your members do it, but it's not standardized and it varies from hospital to hospital. I'd like to ask any one of you—pick among yourselves: If you've had a C. difficile outbreak, when did you start to communicate to the public at large and the community you serve? What were the triggers that made you decide it was time to go and tell the public in your community?

Ms. Bonnie Adamson: We have not had a C. difficile outbreak, but we've had other types of outbreaks. It's

signage and letters to the patients and their families in our organization on a routine basis.

M^me^ France Gélinas: So it's signage, and you go to the patient and family. You never go to the community as a whole?

Ms. Bonnie Adamson: Not as a public release. We deal with patients and their families that are affected only.

Ms. Karen McCullough: We do exactly the same. We've not been in a situation where we've had an outbreak, but on an individual patient basis, if they do receive or acquire a hospital-acquired infection, it's an individual, direct communication with the patient and the family, face-to-face written communication, a follow-up letter, communication amongst the staff and reporting through our infection control committee. We also report each time we have a hospital-acquired infection in our hospital. We send out an e-mail to all of our leadership teams so they're aware of the fact that we do have a hospital-acquired infection and that we need to take some steps to make certain that we have no more following.

M^me^ France Gélinas: If you had an outbreak, would you ever communicate that to the community you work in?

Ms. Karen McCullough: Absolutely. That's something our organization would believe that we would need to do. We have not had one, so I couldn't outline the steps in the process for that, but disclosure is incredibly important in health care these days.

M^me^ France Gélinas: Do you have an internal policy that has to do with public disclosure or communication to the public or anything like this? Or is it your common sense that would tell you, "We want to be transparent. We want to be accountable. Therefore, we'll tell"?

Ms. Karen McCullough: We would have nothing specific in writing to guide our organization in that particular incident right now. Just philosophically, our organization is about disclosure, so if we had an outbreak we would disclose it.

Dr. Jack Kitts: I think that's an excellent question because I think every hospital does their own. Within that you have to determine what is the outbreak, where is it and what would informing the public do to help you prevent it. With each outbreak, we sit with infection control. If it's self-contained, there aren't a lot of visitors and it's a certain unit, maybe not; maybe you don't. If it's something where you can appeal to the public to help you by staying away, not visiting, things like that, we balance the scare of the public not coming for care that they need versus informing them that there's a concern. I hate to say it, but the answer is, it depends. I think the one that we publicly reported and it went out in advance was the MRSA outbreak in the neonatal unit last Christmas—the staph. aureus outbreak in our neonatal unit. We went out and asked the public not to come, and things like that.

It's much better to get it out there proactively than to have the fear in the media, but we do go to the media regularly if we believe the public needs to know and can help us with the outbreak.

The Chair (Mr. Norman W. Sterling): Can I just interject here? As I understand it, C. difficile is now being reported publicly by the ministry, as of September 30.

M^me^ France Gélinas: By each hospital to the ministry, and then to the public. But it's available after the fact.

The Chair (Mr. Norman W. Sterling): Oh, I see. So you're saying that it's the lateness of the report that is your issue?

M^me^ France Gélinas: Oh, no, don't get me wrong. This reporting is very good, and I'll agree with everybody that because we have transparency at that level, it will increase confidence in our hospitals. There's a strict guideline from the ministry that as soon as you have an outbreak, you report to the health unit, and the medical officer of health reports to the ministry. There's a whole chain of command and it's working well.

I was just wondering if there is a similar process that would trigger a communication to the public while it's going on, not a month down the road on the website, although this is very useful. Specifically, you said that you had a—

Dr. Jack Kitts: Staph. aureus.

M^me^ France Gélinas: —outbreak in a particular unit. What were some of the triggers that made you decide that you should let your community know that this was going on?

Dr. Jack Kitts: For me, as the CEO, it's often that the infection control expert comes to me and says, "We have an outbreak. We've been working on it. We've been using all the best practices. We're not getting a handle on it. We need to inform the public."

Kathy, could you come up here and say what triggers you to feel that the public needs to be notified?

Dr. Kathryn Suh: I think it really is a very individual decision based on the population you're dealing with and what the ramifications are to the public, and I think that has been well stated here. I think if we are faced with an outbreak where we are implementing our best-practice measures for health care providers and other individuals working within the facility and we are still not able to control transmission of an organism, then we tend to focus more on visitors and trying to restrict unnecessary visitors from coming in. We may actually ask for additional precautions to be used by some of those visitors, but it really depends on what the population is exactly, whom you would notify. In this particular case, in conjunction with our high-risk prenatal colleagues, we had a mechanism to inform mothers who were imminently about to deliver that we were having a problem and that their care would be directed elsewhere if possible. But I don't think there's a rule that any institution can really go by that would be a sort of checklist for dictating how and whom you would notify.

M^me^ France Gélinas: So, using your clinical skills, you make the best judgment, you advise your CEO. Would you say that this is the way it would work in most

hospitals? People would put their clinical skills together, advise the CEO and—

Dr. Kathryn Suh: I think so. Within our community of infection control professionals and physicians, there certainly is a lot of advice that is shared among the groups. So I think if we are having problems, we all call on our colleagues for advice because they may have handled similar situations and have some advice for us.

Mr. Tom Closson: I think the question you've raised is a really good one, and it's one that we were asked when we were meeting with the media leading up to the initial public reporting on C. difficile. The term "outbreak" is somewhat misleading, because it's a bit of a mathematical calculation. It's not like, outbreak, everybody's at risk. It just says that there's a little bit more than there was a month ago and it flags the fact that we need to be aware of that and see whether we are managing things appropriately.

The real question comes back to who's at risk and notifying those who would be at risk. If there is an outbreak of C. difficile as it has been defined in a particular place in a hospital, that doesn't mean all other parts of the hospital are unsafe to be in at that particular point in time.

Having said that, I think all of us in the health care community have an obligation to the public for full disclosure. Sometimes, if we don't make sure that the full information is out there about what's going on, somebody in the organization phones the media, and then the media puts a story in there that actually could be quite misleading, and that could get the public more upset.

1410

I think this is probably an area we could work on a bit, in terms of coming up with a little bit of clarity and suggestions to hospitals in the province as to the extent to which you use the various mechanisms—your website, your telephone system, signs in the local area, letters to certain people, signs on the outside of the hospital. I think it is something that we've been thinking about but as of now haven't really worked on. I think we could work with PIDAC on something like that.

M^me^ France Gélinas: Thank you. Do I have time?

Interjection.

M^me^ France Gélinas: Oh, Ron, did you want to add something?

Mr. Ron Sapsford: I just wanted to add that the public health system deals with over 2,600 outbreaks every year, again, based on this mathematical calculation. So there is a degree of judgment required as to when do you communicate with the public, because in many cases they may be very isolated, very contained and not really an issue of public risk. In other cases, of course, an outbreak can bring significant risk. I think I'm just seconding the idea that making something public is for a specific purpose as opposed to a general purpose, and that requires some evaluation of what the outbreak is, what its condition is, who it affects and how we can control it.

M^me^ France Gélinas: I get from the comments that were made today that there's room for improvement in there. Would it be mandatory for every case? Probably not. But would it be that everybody makes their own clinical judgment and no guidelines from the ministry on public communication—the hospital association realizing that their members are not always very consistent in the way they handle it—to single hospitals having to deal with it? I'll leave it at that—that we realize that not every outbreak will make the headlines of the Globe and Mail, but at the same time that no guidelines coming from anywhere are maybe not serving our population the best either.

It was mentioned in the auditor's report that one of the hospitals—unfortunately, I forgot which one—is doing a trial for universally screening all patients for MRSA and VRE. Which one—

Interjection.

M^me^ France Gélinas: It's you? I know that it won't be completed till January, but just to give us a sense; it seems so overprotective. But anyway, I'll let you tell us how it's going. And do we have an early peek as to what this research will lead to?

Dr. Jack Kitts: I think if we go back to the MRSA history, our infection control people told us back in 2001-02 that we were pretty confident that we could identify patients coming into our hospital who had come from an at-risk environment: They were coming from long-term-care homes, hospitals in the States, things like that. So identify them up front: Are they at risk? If they are, let's screen them and see if they have the MRSA bug.

It became evident over the next couple of years that there were more breaches in terms of identifying who's at risk, and therefore there were breakdowns in the screening. So if you have a screening mechanism that doesn't work, the question then becomes, do you stop it or do you screen everybody? The discussion around the senior table was not easy. The implementation of universal screening in our hospital was an investment of over $1 million in trying to prevent MRSA outbreaks.

M^me^ France Gélinas: For that one year for that one unit?

Dr. Jack Kitts: For one year for the whole hospital.

M^me^ France Gélinas: For the whole hospital.

Dr. Jack Kitts: Yes. We're doing it hospital-wide. So if we can prevent an MRSA outbreak, if we can prevent a loss of life or limb, that's worth it. But we agreed at the senior table that if we were going to make an investment of this kind, this magnitude, we have to have a way to evaluate whether universal screening is better than specific screening. So Dr. Worthington, who's here—he's the vice-president responsible for that—has put together a framework for monitoring the evaluation, which will be discussed in January, because budgets are tight and there are lots of other important things. I hope we'll be able to prove that it's been highly effective in saving costs from outbreaks and saving life and limb of infected patients. We'll see.

M^me^ France Gélinas: I think I heard somebody confirm this and I read it in the auditor's report, but right now we don't know the costs to our hospitals and our

health care system of hospital-acquired infection. Do you know it for your own site?

Dr. Jack Kitts: I think what you could do is try and cost out the entire impact of an outbreak, but it is extremely widespread, extremely complex, cohorting patients who were in a two- or three-bedroom into one room, cancelling elective surgery because you don't have the beds—the domino is immense. Suffice to say that the cost of an outbreak is immense and probably far more than anyone would measure.

M^me^ France Gélinas: Okay.

Mr. Tom Closson: PIDAC's best practices for the infection prevention and control program estimates that antibiotic-resistant organisms increased direct and indirect costs to hospitals by an additional $40 million to $52 million a year in Canada. These were expenses associated with readmission due to infection, prolonged length of stay, prolonged wait times, longer staff hours. Now, that's for all of Canada. Actually, to me, the number sounds a little bit low, because if that's what it is, I expect we're going to spend more than $52 million trying to reduce those costs. If you can spend $1 million in one hospital just to do universal screening and the savings to the whole of Canada from doing everything is $52 million, it doesn't seem to be a cost-benefit other than the fact, obviously, that patients are harmed by what happens here.

M^me^ France Gélinas: Right.

Mr. Tom Closson: So I'm not sure, based on that, that we actually have a full grasp of what the true cost is.

The Chair (Mr. Norman W. Sterling): Dr. Gardam, did you want—

M^me^ France Gélinas: That's the impression I had, also.

Dr. Michael Gardam: I just wanted to make the comment that in organizations I've worked with on their C. difficile outbreaks in Ontario over the last two years, their additional costs in terms of trying to control those outbreaks have ranged anywhere from $750,000 to $3 million or $4 million, depending on the organization. That's specifically related to C. difficile. The way they've calculated that is not an actual theoretical model, but actually adding up all their costs at the end when they've hired more housekeepers, they've brought in new product and they've done a variety of things. That's the kinds of costs that they were talking about for those outbreaks.

The Chair (Mr. Norman W. Sterling): Okay. Now we're going to go to Mr. Ouellette.

M^me^ France Gélinas: What happened to my extra minutes?

The Chair (Mr. Norman W. Sterling): You're over by a minute. You got your extra minute.

Mr. Jerry J. Ouellette: Just to follow up on the notification and communication, there's been a lot of discussion about within the hospital structure system. However, are there any protocols for notification and communication that play out for long-term-care facilities, Deputy Sapsford?

Mr. Ron Sapsford: Public reporting?

Mr. Jerry J. Ouellette: Yes.

Mr. Ron Sapsford: No.

Mr. Jerry J. Ouellette: So what would the protocols be in the event that a hospital perceives that a long-term-care facility happens to be an identified site or a high-risk site? What are the notification requirements for interaction between the two or within the facility itself?

Mr. Ron Sapsford: Long-term-care outbreaks, again, are through the health units. So the medical officer of health would be notified and then, accordingly, the control measures would be brought into place. Similarly, if there's a patient identified, for instance, at a hospital, then communication between the hospital and the long-term-care facility would ensue. As to the detailed response of the health unit, I'd ask Dr. Williams to speak to that.

Mr. Jerry J. Ouellette: Okay.

Dr. David Williams: I guess historically, because long-term care is under a different act, they do have a closer working relationship with the public health unit so that the medical officer of health and staff do give support to that and, as a result, are involved in any notification of cases and outbreaks, and we're going to team partnership to deal with the outbreaks as they have done with your gastrointestinal, respiratory or otherwise, for a number of years now.

Mr. Jerry J. Ouellette: Mr. Closson, a question: To your knowledge, has there been any communication by any of the health insurance providers that hospital infectious diseases may not be covered by that insurance provider?

Mr. Tom Closson: You're talking about for extended health insurance? Like private and semi-private?

Mr. Jerry J. Ouellette: Yes. We understand that in the United States there's been notification to health care providers that the insurance providers are pulling away from providing service at certain sites.

Mr. Tom Closson: I haven't been notified of anything like that. However, if a patient needed to be put in a private or semi-private room to be isolated from other patients, then the insurance company, I'm sure, would not want to be paying for that because the patient needs to be in that room for medical reasons, as opposed to that they chose to be in that private or semi-private room. I don't know if that's what you're getting at. I suppose if the insurance company felt that somebody was trying to pull a fast one on them, they would—but normally a hospital would not charge the insurance company for a situation like that.

1420

Mr. Jerry J. Ouellette: Dr. Kitts?

Dr. Jack Kitts: It's an excellent question. Many insurance companies are now making overtures that they're not going to cover for semi-private, because many hospitals have gone to two beds to a room, so why would they pay a differential for that?

We believe that the right result in the future is one patient per room, in which case the whole insurance for semi-private and private goes away. The providers are

very much aware of that and it is decreasing. It is a substantial revenue for hospitals, so hospitals have to be aware that as we move forward with better infection control practices, the revenue stream from insurance does go down.

Mr. Tom Closson: I didn't understand that that was the question you're asking. The government of Ontario only funds hospitals about 85% of their true cost of operating. It varies a lot from hospital to hospital. So they use other sources of revenues to attempt to balance their budget, and preferred accommodation revenue is a big part of that. At a place like the University Health Network where I used to be the CEO—that's Toronto General, Toronto Western and Princess Margaret—I'm going from memory now, but it's probably as much as $15 million, $20 million, a year in private and semi-private accommodation. So if you built a hospital with all private rooms, you'd have to figure out where the money was going to come from to actually make up the difference that's now being paid for by the insurance companies.

Mr. Ron Sapsford: Just on the point there, there has been a growing trend in other countries, particularly the US, not so much on the payment for private rooms, but where there are hospital-acquired infections, of insurers taking positions that they won't pay for the coverage of that and that that should be the responsibility of the hospital. It goes along with the increasing emphasis on quality assurance and quality outcomes and where the outcomes are as a result of misadventure inside the hospital—that third parties should not be responsible for it. I think that perhaps is part of what you were referring to. Being the insurer in Ontario, however, we have not yet taken that position.

The Chair (Mr. Norman W. Sterling): I might add at this juncture that it's our hope—I've gone to the various parties—to complete the hearings by 3 o'clock, before routine proceedings take place, because we can't have a committee sit during that period of time. We'd have to recess for three quarters of an hour and require everybody to come back. So those people who have travel plans can be assured that we'll try to complete it by 3 o'clock.

Mrs. Witmer.

Mrs. Elizabeth Witmer: I would like to first of all thank the Auditor General for what I think is an excellent report, and also for raising the awareness and providing us with some great recommendations as to how we can move forward. I think it was certainly acknowledged that the hospitals that were visited are doing the best job they can. However, there was also an indication that there's room for improvement.

Of course, one of the areas mentioned was the fact that the use of antibiotics has contributed to the problems that the hospitals face with this increased incidence of C. difficile and MRSA. He has also pointed out that hospitals are all doing something just a little bit differently in monitoring this.

I would ask the hospitals, and I know that the ministry is undertaking a study: What needs to be done and how can we ensure that there is judicious use of antibiotics?

Mr. Tom Closson: I'll just start generally on this issue. This is something we've discussed a lot with Dr. Baker, who's leading up the work for the ministry. We do believe that this is a significant issue in terms of antibiotic resistance, and it's obviously a significant issue in terms of the cost of running hospitals too, because if we're over-prescribing antibiotics, it's a bit of a waste of money. This is something that would tend to be dealt with through the medical advisory committee of a hospital, because they would be looking at what the prescribing practices are and the extent to which the hospital or the medical department heads and the MAC would want to manage that process. Some hospitals are farther along in that regard. There is work going on, and I think that's probably what you're referring to. The Ontario Agency for Health Protection and Promotion, of which Michael is now part, but also the Institute for Safe Medication Practices Canada, which Dr. Allison McGeer from Mount Sinai is quite involved with, have been working on a program to support hospitals and actually managing antibiotics well. So there's lots of room for improvement in this area, but I think we are going to get some assistance.

Mrs. Elizabeth Witmer: I guess what I see here is a recommendation that there needs to be some assistance, there need to be some guidelines. The hospitals simply don't all have the resources—nor should they—to be operating differently.

Dr. Michael Gardam: Yes, I would certainly echo your comments that this is a very important area. It's also an extremely challenging area, for a number of reasons. One, we're talking about physician prescribing practices. That is a challenging area to get a handle on because it means that somebody has to be overseeing those practices and commenting when they're not necessarily appropriate. Even large teaching hospitals that have a number of infectious disease physicians and microbiologists find this challenging, because essentially the best practice documents talk about having somebody overseeing this full-time. So you can imagine, if academic centres are having a challenge—smaller centres don't have those people—it becomes very difficult to actually be able to oversee this. That being said, the work that others have mentioned is looking at the lay of the land right now, what work is being done out there, and is there potentially low-hanging fruit that we can jump on and work on? But there's no doubt going forward—and this will take, I think, many years—that this is something of great interest to the agency as we try to chip away at this problem. But it will be a very long-term strategy.

Mrs. Elizabeth Witmer: So you don't see anything in the short term, any guidelines being provided to the hospitals?

Dr. Michael Gardam: As I was mentioning, there certainly is some low-hanging fruit—for example, making sure we're standardized around which antibiotics to give to people prophylactically when they have surgery. There are some things like that where there are existing guidelines that are relatively easy for us to disseminate, for pharmacists to follow up on, for hospitals to

have order sets that are following this. So there are some things we can definitely do there. Other issues that involve somebody coming in with pneumonia and a doctor choosing antibiotic A versus B—that's going to be a little bit more difficult because we're going to have to have somebody oversee that and be able to make a call on whether that was the right drug or not.

Mrs. Elizabeth Witmer: What about the area where, again, it was noted that there was some room for improvement? Is the fact that the hospitals had different policies on when to isolate patients with infectious diseases in private rooms—what type of guidelines or directions might be given by the ministry or yourself?

Dr. Michael Gardam: PIDAC certainly has provided guidance on that. There's always allowance for some wiggle room. The reason I say that is because if you've got a newer facility that has many more single rooms, it is far easier to bring in policies that perhaps may be more aggressive. For example, some hospitals will assume you have something until we've proven you don't have it. In other words, we will isolate you while we're waiting for the results to come back. If we were to do that at the UHN, we would be in big trouble. We don't have enough single rooms to be able to do that. So if a hospital has the ability to do that, great; good for them. They should go ahead. For other facilities, the physical limitations don't allow you to do that.

PIDAC does have best practices, and it's been my feeling that in general, that's an area where people are fairly consistent. If they're doing more, it's because they're able to do more. This is something that I hope becomes a thing of the past when we start building hospitals with 100% single rooms.

Mr. Tom Closson: I'd just like to speak to the capital piece, which I think is very important here. The average hospital building in Ontario is 46 years old, and we figure there's about $8 billion of capital construction that needs to take place to bring hospitals into more modern design. That actually was before we got the sense that we should be having a lot more single rooms, so probably, if we looked at it now, we'd come up with an even bigger number. But the public-private partnerships model has allowed us to move ahead, and there are $5-billion worth of capital projects that are ongoing right now. I think Ron referred to a number of those projects where decisions had been made, almost on the fly, it seems, to increase the number of single rooms just to try to address this issue. But for older hospitals—and UHN isn't all that old, because Princess Margaret was 1998, and Toronto General and Toronto Western—a lot of them have been rebuilt, but the designs were done before people realized how significant this issue was. With hospitals operating at 100% capacity, it really is a challenge to do what—and that's why, as Michael says, different hospitals do different things, because they're just trying to cope with how to deal with their situations.

1430

Mrs. Elizabeth Witmer: I guess that's my concern. I would say, based on all that we've seen, that I personally think hospitals have done an admirable job of coping and responding to the outbreaks of disease that they've encountered. But there is obviously a need for some support; there is a need for some guidelines.

I think you have raised a really good point. If the recommendation is that there needs to be more of these single rooms, how do we make sure people in the older hospitals are protected? Is there anything contemplated, Mr. Sapsford? Some of these projects are on hold. We've got old, decaying, decrepit hospitals. Nothing is happening. They don't have private rooms, let alone sometimes enough of the semis. What needs to be done? It seems to me, there's a lot that needs to happen very quickly.

Mr. Ron Sapsford: Of course, the long-term solution is either renovation or reconstruction. As Tom has said, there's quite an aggressive capital program going on. So as we look at new construction, whether these are full new buildings or whether they're renovating to include more of the environmental solutions—hand-washing sinks, flow of clean and dirty supplies through a unit, as well as the question of number of beds—it will be part of the design criteria.

For hospitals that are basically operating without a capital program at the moment, they're more into these operational considerations, so that when an outbreak occurs, cohorting of people, using semis for only one patient—which then causes operating pressure in terms of the number of patients the hospital can deal with at any one time. But beyond those kinds of operating considerations, there's not very much one can do when you're in the midst of an outbreak; hence, the identification, isolation and control of an outbreak is the most expedient response that a hospital can make when there is a problem.

Mrs. Elizabeth Witmer: I realize I have just a few minutes left, and you can certainly try to respond, but I want to ask the three hospital leaders that are here today: What additional tools do you need to ensure that you can do everything possible to, first of all, prevent these outbreaks, and if they occur, to obviously make sure that you respond to them as quickly as possible?

Dr. Jack Kitts: I think that's an excellent question. We know what the right answer is: It's single patients per one bathroom, one-patient single rooms. I would follow up on the capacity and indicate that we could free up significant acute care capacity if we could move the alternate-level-of-care patients to the appropriate level of care—I would argue probably, in some cases, a 30% to 40% increase in capacity, which would allow us to practise better infection control patterns.

Mrs. Elizabeth Witmer: And Ms. Adamson?

Ms. Bonnie Adamson: I would agree with Dr. Kitts. Currently, we have 50% of our medical beds with patients who belong in—

Mrs. Elizabeth Witmer: Fifty per cent?

Ms. Bonnie Adamson: Of our medical beds, so we have 80 patients most days out of 150 to 160 beds who belong, about 50% of them, in long-term-care facilities and the other 50% in either rehab beds or complex con-

tinuing care. That creates congestion in the medical wards. The emergency room gets backed up. We have 100,000 visits every year. Every morning, we have 20 to 30 patients waiting for admission in those beds, and it backs up right into the waiting room. So that is a flow issue, but it translates into a very high-risk situation for infection control prevention. So that's a huge—working the system to work together to move these patients, and there are a number of strategies on the table about making that happen.

Mrs. Elizabeth Witmer: Thank you. Ms. McCullough?

Ms. Karen McCullough: I wish I couldn't relate to that.

Mrs. Elizabeth Witmer: How high is your ALC load?

Ms. Karen McCullough: Our situation load is not all that different.

I would be thinking of a slightly different tool, though, and a little bit more global. I believe a lot of the problems could be resolved by improvements in technology. If we had electronic patient records, if we had physician portals, if we had documentation systems that basically were seamless to our patients, we wouldn't all be in a situation where we're trying to figure out whether somebody has MRSA or VRE; we would actually be tracking that patient through the system. We would be able to monitor and track the utilization of antibiotics. We would be in a much more knowledgeable situation, where I think in the future we would be able to better manage, control, make informed decisions, and work with our patients and communities. So I see technology as a huge tool.

Mrs. Elizabeth Witmer: Speaking on behalf of the hospitals, Mr. Closson, what tools do you see the hospitals requiring? Maybe you would agree with both of those points.

Mr. Tom Closson: I think both of those issues are really high priorities.

I think the hospital sector would say that the most difficult thing they're facing at the moment is the ALC issue. It's 20% of beds overall. About 37% of medical beds in the province have people who would be better cared for in the community. So this isn't a matter of adding more hospital beds; this is about more home support, more assisted living etc. Having said that, as you know, the ministry has appointed Alan Hudson to work on this. We're working very closely with Alan, and we hope that the initiatives that have been announced will actually make a big difference in this.

On the e-health side, I couldn't agree with that more—having electronic health records so we get better surveillance. A new public health surveillance system for all of Canada, which is being developed in BC, will be going into place. Ontario is one of the first provinces to implement it. We need to link better into the hospitals. The government has said that e-health is a priority, so I'm hopeful that we'll make progress in that area as well.

Mrs. Elizabeth Witmer: Well, Dr. Hudson has the responsibility now.

Mr. Tom Closson: He's got that one. Sometimes I wonder what we would do without Dr. Hudson.

Mrs. Elizabeth Witmer: I'd ask you, Mr. Sapsford—and you've done an admirable job as the deputy for a number of years now: What tools do we need to provide for hospitals or for the ministry? Is there something that's needed that could be done?

Mr. Ron Sapsford: I think I would agree with my colleagues about electronic information. If you go back to 2003 to SARS, you'll remember that many of the control mechanisms were done on pieces of paper. We move in a very fast-paced environment and a very complicated environment in hospitals. Anything we can do to speed the flow of information allows us to respond more quickly and to put the necessary control mechanisms. The Panorama system that Tom referred to, which is the public health part—the surveillance, tracking and monitoring—will include immunization, so that over time, Ontario citizens' immunization histories will be a much better clinical management tool. I think any investments in those areas are very important.

I think of the continued work of PIDAC—you yourself mentioned the antibiotic usage—anything that looks at the culture in which health care operates around this area. Yes, we know what to do, but making sure that people respond in an appropriate way and the culture and the attitude of the health care system to these issues are things that we need to spend more time on, focusing on how we change the attitudes and behaviours in the health care system to respond to these kinds of issues.

What's the tool we need? That's a harder question. But I think working together, as clearly you can see today, with individual hospitals—the association plays a large role in this, and the ministry, as well as LHINs—to keep the focus on it and to keep the priority of keeping people safe and free of disease is where I think we need to spend more time as we go on.

The Chair (Mr. Norman W. Sterling): Mr. Balkissoon.

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Mr. Bas Balkissoon: Let me open by saying thank you to all of you for being here. As a new member of our government, it's a pleasure to hear all your knowledge shared with us.

My question is for Mr. Closson. I just want to go back to a statement you made. You said that PIDAC best practices were issued and had gone out to all the hospitals, and you're interested in going out to the hospitals and seeing if they're being used consistently across the system. Earlier, everyone here said that raising awareness of the hand-washing situation is what is required, and sometimes the best way to know if you're successful in raising awareness is by measuring yourself.

The ministry has indicated that all hospitals will report on eight indicators by April 2009. The auditor, on page 10 of his report—and I know he's making a general statement—has said that HAIs were not comparable because the hospitals differed in how they defined and counted them. Are we going to see, by April 30, when the hos-

pitals are all starting to report, that they're reporting on consistent measurements and that the data they're collecting using the ministry's website—that everybody's being measured with the same yardstick and the same monitoring process?

Mr. Tom Closson: I think we're going to share this answer. I want to say, first of all, we've been working really closely with Michael Baker and the ministry about definitions to make sure we do get consistent reporting.

You did make reference to hand-washing. I want to make sure it's clear: It's not that health care providers don't wash their hands; they do wash their hands. But do they wash them at the appropriate times: before they contact a patient, after they contact a patient, before they do an aseptic procedure, after they've been in touch with any body fluids? These are the four times. Then they have to wash them a certain way and then they have to do it for 15 seconds. When they're being audited, if they don't do all those things, then they haven't washed their hands appropriately. That's what I mean.

Even the definition is important—like, what is hand-washing?—and having the audits done in a consistent way to really determine the extent to which it's happening within organizations.

Mr. Bas Balkissoon: That's what I'm concerned about. Are all the hospitals going to use the same yardstick for auditing and reporting?

Mr. Tom Closson: Yes, they are.

Mr. Bas Balkissoon: They are.

Mr. Tom Closson: Yes.

Mr. Bas Balkissoon: Okay.

Mr. Ron Sapsford: Part of the work that's going on now—we've had C. difficile reporting now since September, and for the remaining six or seven, part of the work we're doing now is exactly that: What is the definition? How shall it be reported? What are the tools to report it? So that when hospitals in fact do report it in April, there is consistency.

One of the important things in public reporting is, we want to make sure we can make comparative statements between hospitals so that they can judge their own performance against their peers. That work is now going on.

Mr. Bas Balkissoon: Okay. Thank you very much.

The Chair (Mr. Norman W. Sterling): Mrs. Albanese?

Mrs. Laura Albanese: My question is actually very similar to that of Mr. Balkissoon. I wanted to know a little bit more about that. What are the criteria that will be behind this consistent reporting?

Mr. Ron Sapsford: The criteria?

Mrs. Laura Albanese: Yes. In other words, how have you established those criteria? Has there been training that has been done with all the hospitals in what the criteria are, going forward, and what we will see in April?

Mr. Ron Sapsford: I'll start generally, and Dr. Vearncombe can probably—because for each disease, there's a separate set of criteria, so the definitions, the meaning of words and how cases are identified really is a scientific, clinical question. We're working with PIDAC and others to do that. Perhaps Dr. Vearncombe can give you some instances.

Dr. Mary Vearncombe: That's absolutely correct. For each one of the indicators, there is a specific definition and a specific way of collecting the data. For each indicator, we are partnering with the OHA and also with the regional infection control networks through a train-the-trainer kind of program to provide education to all of the hospitals so that they understand the definitions, understand how to collect and submit the data. Each one has its own specifics and its own training. But we are working very, very hard to have everything standardized.

Mrs. Laura Albanese: And that standardization will be reflected in the public reporting?

Dr. Mary Vearncombe: Yes.

Mrs. Laura Albanese: Okay. Thank you very much.

The Chair (Mr. Norman W. Sterling): Ms. Gélinas.

M^me^ France Gélinas: One quick question for the deputy: In the ministry's response to the auditor's recommendation, you indicated that the public reporting of hospital-acquired infection will be expanded to include patient outcomes—and I have asked that death certainly should be reported. When is this expected to occur?

Mr. Ron Sapsford: Patient outcomes—

M^me^ France Gélinas: That was in your response to the—

Mr. Ron Sapsford: Yes. I can ask one of the doctors to respond. In general terms, patient outcomes—which generally, for C. difficile and others, we're speaking now of death as being one of the potential outcomes—again, is a definitional issue. While I don't put it away as not wanting to consider it, if we're going to report it publicly, as is the question, then we need to make sure that when we do that, we've got clear definitions—how we count, how we report—because when you start that public reporting, people will naturally want to make comparisons. So it's more for those reasons than any other reason.

The time frame? I can't give you a date today, although simply to say that it is an active question and it has been referred for consideration.

Dr. Michael Gardam: If I can just fill in a few of the details there: The agency is working on that exact question, and we've been speaking to our colleagues in Quebec and other jurisdictions to find out how they've done this. What we've learned thus far is that jurisdictions that have gotten involved in this have found lots of challenges in terms of the reproducibility of determining what somebody died from. I know that sounds a bit odd, but with C. difficile it's actually quite difficult to determine what exactly caused death. So we're learning from that and we also are in the process of developing the actual protocols that we want to use for this. But in terms of time frame, we're expecting that for us to have something ready to go and rolled out and actually working, we're probably looking at the better part of a year.

M^me^ France Gélinas: I think it was said clearly in the auditor's report—and I think, Tom, you've mentioned it as well—that a certain percentage of the population have

those bacteria; because of immunodeficiency as a result of disease or treatment, they will get sick. But there are also other patients who contract those bacteria through another patient, through the fact that they are in the hospital. They never carried the bacteria to give them those infections; they got them because of their neighbours in the next bed, because of the nurse, because of the doctor etc. When you do identify a case, do you note a difference between the two—if it's a case that came through immunodeficiency by sickness or treatment versus somebody who clearly got it from another patient or staff member?

Mr. Tom Closson: That's a definition as well as to whether it's hospital-acquired or the person came in with it. I think it's if the symptoms show up within 48 hours. Is that—

Dr. Mary Vearncombe: Seventy-two hours.

Mr. Tom Closson: It's 72 hours. So you see, that was one of our definitional problems at the outset, because some hospitals were using 72 and others were using 48. So they've decided on 72, and that way we all report consistently.

M^me^ France Gélinas: So it would be considered hospital-acquired if it's 72 hours?

Mr. Tom Closson: That's right.

M^me^ France Gélinas: I was a little bit intrigued by the response you gave to Mrs. Witmer when she asked you what kind of tools the government, the ministry, the OHA can give you to bring down the rates of hospital-acquired infections. None of you said, "We need help to get our doctors to prescribe antibiotics in a better way." None of you said, "We need help in getting our staff to wash their hands for the appropriate amount of time" etc. You went to the need for private rooms; you talked about capacity and linked that to ALC; and you talked about technology. Are we putting our resources in the wrong direction? I just open it up to you. I was surprised by your answers.

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Mr. Tom Closson: Maybe it was the interpretation of the question.

M^me^ France Gélinas: I don't think you answered those questions. The three executive directors answered.

Mr. Tom Closson: So you still don't want me to answer on their behalf?

M^me^ France Gélinas: Sure, but let them go first, and you go second.

Dr. Jack Kitts: I think it's probably two different directions or focus areas. Do I believe that PIDAC and those sorts of groups should continue to give us best-practice guidelines? Absolutely. Many of us actually don't wait for PIDAC, and many of our members are on PIDAC, so we're creating a lot of those best practices in our organizations.

If we're truly going to change the impact on infection control, give our health professionals the capacity and the environment to work in. A nice, brand new, shiny, clean hospital is a great start. If you can't have that, then at least have the capacity to not have patients bunched in together.

I think number one is, give us the capacity, and number two is, amazing things happen with health professionals if you can actually show them the effect of their work. ISIT is absolutely essential.

Ms. Bonnie Adamson: I would add that the issues of handwashing change in behaviour and medical-practice ordering of antibiotics are requirements of the organization to be accountable, to work with the team inside the organization to change their behaviour, so teamwork and interdisciplinary care. We're accountable as agencies to provide the leadership, the accountability systems, and work together with all of the partners within your organization to make the change occur. We receive all these expert resources from OHA and from the government based on best practice. It's our accountability, the board's and the leadership of the organization's, to work with the right individuals and right teams inside our organization to make it effective at the front line. It's about changing behaviour and it's all about leadership.

Ms. Karen McCullough: Exactly the same. When I said that one of the tools that we'd need would be e-health, that's because I believe that in the future, we will be needing that. At this moment in time, however, I strongly believe that it's an individual hospital's accountability and responsibility to do the very best that it can with what it's got to ensure that it's not in fact experienceing hospital-acquired infections. It is our accountability to wash our hands well at the right time, it is our accountability to tell the staff how well they're doing or how well they're not doing in those endeavours, to report it to the board and to the public.

We have many of the tools that we need now. We've had a lot of assistance with our hand-washing hygiene campaigns. We've had a lot of assistance with additional resources as infection control practitioners. We have a lot of tools; we need to use them. In the future, we'll be needing additional tools.

M^me^ France Gélinas: Okay. Tom, I will ask you the next question. It's about the same thing, but I'll add a twist to it. If a hospital had the appropriate amount of private rooms, the full usage of their beds, the alternative-level-of-care clients cared for where they should be cared for, the technology in place that allowed us to track prescribing habits, good hand washing, and the culture of cleanliness that we've talked about, do you figure we could get rid of hospital-acquired infection?

Mr. Tom Closson: No, because there are always going to be some mistakes made.

I'll take you back to SARS. When we had SARS II, as we called it, I was the CEO of the University Health Network. We really believed we were following the standards of protecting our staff. Then a patient—who was called a super spreader because they'd had a lung transplant and therefore was on all sorts of drugs for their immune system—who had SARS was transferred to us from another hospital and four of our staff got SARS in the emergency department, even though we thought they

were taking every possible precaution. We were so careful during that period. I don't think you could ever have been more careful than we were.

So mistakes get made, or maybe in some cases we just don't understand what caused something to happen. There are always going to be some. What we're trying to do is really minimize the likelihood of it happening.

M^me^ France Gélinas: If I go to the CEOs—I don't know if you remember the little rosy-looking pictures I've just given you. You have the private rooms you need, you have—do you remember? What kind of a difference would it make for your hospital?

Dr. Jack Kitts: I think we could stand up in public and say that this hospital is as safe as it possibly can be. I don't think we can ever give 100% guarantees because of the human element of it, but we could stand up as hospital CEOs and say, "This is as safe as any hospital can be."

M^me^ France Gélinas: How about you?

Ms. Bonnie Adamson: I would agree with that answer. It's assuring the public that we are doing the very best we can in the set of circumstances we find ourselves in. We've maximized the tools, we've supported our staff, we've created an environment of safety and learning, that people are not punished for what happens and that we can then bring the best out in the human resources we have.

Ms. Karen McCullough: Exactly, and I think the key point is, "when we've failed." When as an organization we have a situation where a patient does in fact experience a hospital-acquired infection in our perfect world—and I can't wait; that's going to be beautiful—when that happens, our accountability and responsibility is to investigate on an individual basis to find out what went wrong. It's always about lessons learned. We'll never be perfect. Humans are not perfect; we make errors. But it's finding out the root cause, identifying the source of the error and making certain that that doesn't happen again.

The Chair (Mr. Norman W. Sterling): I'm going to end the questioning there. I'd like to thank everybody who has travelled here, who has come here. I invite any of you to write to us on any of the questions, and if there are some clarifications you might want to offer to the committee, we would appreciate it very much. We'll be writing the report probably about a month from now, and our researcher will be at it within that period of time—so that time constraint.

I would recommend to you for reading the report which this committee tabled—those of you who have not already seen it—on September 22 on operating rooms and the use of those facilities. I just talked to the clerk; I had understood that we were sending it to all 157 hospitals, but he only sent it, as I understand, to the three hospitals that were under consideration at that time. So we're going to send it to all of the other hospitals.

In that light, I would say to you that part of the role of this committee, or a very important function to members of this committee, is that if we can help you who run our hospitals, who work in our hospitals, and the senior management deal with this issue in a better manner and encourage your boards, your senior managers who are not with us today, and your staff to undertake better practices with regard to this, we would ask you for any kind of recommendations we could make in that light, so that you can use us as the recommenders, if that's necessary, in order to have change occur in your particular hospitals.

I'd like to just call on the Auditor General. He wanted to make a brief remark.

Mr. Jim McCarter: I'd just like to take 30 seconds to thank the three hospitals for the co-operation extended to our staff. I suspect it's no surprise that when people get a call from the auditor, it's not always good news—often I get 10 seconds of stunned silence—but I have to say that the three hospitals were very receptive to us coming in to do our work. They certainly made the time of their specialists available to Susan and our staff, so I'd like to pass along our thanks for the co-operation.

The Chair (Mr. Norman W. Sterling): Thank you very much. And you can hear the bells going. The Legislature is about to convene, and we have to end when it convenes. Thank you.

The committee adjourned at 1458.

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The Ottawa Hospital
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