Auditor's Report finds that more can be done to improve patient safety in Ontario

Bonnie Lysyk, Auditor General of Ontario, tabled her Annual Report in early December. The report includes ***the*** *Value-for-Money Audit on Acute Care Patient Safety and Drug Administration. A key focus of the Audit was on the safety of medication processes in Ontario hospitals. ISMP Canada representatives were pleased to be interviewed as part of the audit process. In addition, the Institute was referenced as a key patient safety organization that shares best practices for reducing medication errors.*

In the introduction of the *Audit on Acute Care Hospital Patient Safety and Drug Administration* Report, the Auditor-General noted the following.

• Each year, among the more than 1 million patient discharges from Ontario acute-care hospitals, approximately 67,000 patients were harmed during their hospital stay. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital.

• This is the second-highest rate of hospital patient harm in Canada, after Nova Scotia.

• Public concern with the safety of health care has increased in recent years due to growing research on the impact that medical errors and hospital-acquired infections have on patients and on the health-care system.

One of the areas identified where safety of care is frequently compromised is around medication and medication administration.

While the vast majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals they visited are committed to patient safety, the audit team concludes that more can be done to improve patient safety.

Here are some of their significant findings as they relate to medication safety.

- Between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices.

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

- Hospitals do not always follow best practices for medication administration. From 2012 to 2018, hospitals in Ontario reported 154 critical patient safety incidents involving administration of medications. Thirty-nine of these incidents resulted in a patient's death. They found that three of the hospitals they visited did not always comply with best practices for the administration of high-risk medications, such as using an independent doublecheck to verify medication and dosage, witnessing patients taking and swallowing medications, or confirming the identities of patients.

- According to the Canadian Institute for Health Information, events associated with medication are among the most frequent of all harmful events possible in a hospital.

This Report contains 22 recommendations, with 38 action items, to address the audit findings. Appendix 8 (pg. 116) lists the recommendations and shows the stakeholders whom they are addressed to.

Audit Team References ISMP Canada Roles

ISMP Canada was referenced in the report in a number of different ways.

1. To gain a fuller perspective on patient safety, ISMP Canada was interviewed by the Audit Team as one of several relevant stakeholder groups.
2. ISMP Canada is listed as one of the organizations [Figure 6 (pg. 77)] that receives voluntary reporting of patient safety information by hospitals.
3. ISMP Canada is listed as the organization [Appendix 2 (pg. 110)] that provides best practices in preventing medication errors.
4. ISMP Canada is listed [Appendix 5 (pg. 113)] as a national not-for-profit organization committed to the advancement of medication safety in all health-care settings.

"The Auditor's report provides crucial data and recommendations on the need for improvement in Acute Care Patient Safety and Drug Administration," concluded Ms. Hoffman. "ISMP Canada looks forward to further collaboration with hospitals and other patient safety stakeholder organizations to improve medication safety and reduce needless harm to patients and families across Ontario."

The Acute-Care Hospital Patient Safety and Drug Administration Audit Report is available here: http://www.auditor.on.ca/en/content/annualreports/arreports/en19/v1_301en19.pdf

The **Institute for Safe Medication Practices Canada (ISMP Canada)** is an independent national not-for-profit agency committed to the advancement of medication safety in all health care settings. ISMP Canada works collaboratively with the health care community, regulatory agencies and policy makers, provincial, national, and international patient safety organizations, the pharmaceutical industry, and the public to promote safe medication practices. ISMP Canada's mandate includes receiving and analyzing medication incident and near-miss reports, identifying contributing factors and causes and making recommendations for the prevention of harmful medication incidents.

A Key Partner in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)