PROVINCIAL AUDITOR
of Saskatchewan

NEWS RELEASE
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June 8, 2021 | Regina, SK

2021 Report–Volume 1: Provincial Auditor Reports More Needed to Improve Patient Safety

REGINA, SK., June 8, 2021: In her *2021 Report – Volume 1*, Chapter 6, Provincial Auditor Judy Ferguson reports the need for the Ministry of Health to better utilize reporting of critical health incidents as a tool to improve patient safety. A critical incident is a serious adverse health event that did or could have resulted in serious harm or death of a patient.

The Ministry is charged with overseeing mandatory reporting of critical incidents, evaluating the likelihood of identified corrective actions will prevent recurrence of future incidents, and helping address system-wide concerns affecting patient safety.

The audit found the Ministry does not determine whether it is notified of all critical incidents. Audit analysis suggests underreporting of incidents. For example, between December 2019 and September 2020, the Saskatchewan Health Authority reported to the Ministry 17 critical incidents related to medical devices whereas, for the same period, it reported 24 incidents for medical device failures to Health Canada.

Key Facts

- Laws require Saskatchewan healthcare organizations (like the Saskatchewan Health Authority) to report critical incidents to the Ministry of Health, and identify and take steps to address their causes
- Critical incidents can cause emotional strain and stresses on both patients and healthcare providers, and result in significant costs (e.g., longer stays in hospitals).
- Hospitals and long-term care facilities report the most critical incidents
- Highest categories of critical incidents in 2019-20 included pressure ulcers, falls causing death, suicides while in care, and medication errors

The audit found the overall number and types of reported critical health incidents are not trending downwards in Saskatchewan, with mainly the Authority reporting over 200 critical incidents in each of the last two years. Also, in 91 reported critical incidents in 2019-20, a patient died.

As well, the audit found the Ministry did not encourage prompt critical incident reporting. The Authority often submitted to the Ministry critical incident notifications and reports late. On average, the Authority took over 100 days to report. Delayed reports result in delays in the Ministry evaluating the robustness of Authority-planned corrective actions, which delays properly addressing contributing factors.

Also, the Ministry does not monitor whether the Authority addressed the identified causes of reported critical incidents. The audit found over two-thirds of corrective actions were reported as not implemented by the Authority. Sufficient actions should reduce, over time, the degree of injury and the kinds of critical incidents that occur in specific facilities. Ferguson notes, "Not knowing whether corrective actions are taken increases the likelihood of recurring patient harm or death."

Furthermore, the Ministry does limited analysis to identify whether system-wide improvements are needed to keep patients safe. While the Ministry periodically issued patient safety alerts, very few of those issued in the last three years related to the highest subcategories of critical incidents reported (e.g., medication errors). Patient safety alerts are to communicate patient safety information for the benefit of the broader healthcare system.

Research suggests about one-third of critical health incidents in hospitals are preventable. Ferguson reports, "If used well, reporting of critical incidents can be an effective tool in improving patient safety."

The full Provincial Auditor's *2021 Report – Volume 1* is available online at www.auditor.sk.ca.

The Provincial Auditor is an independent officer of the Legislative Assembly of Saskatchewan. The Office promotes accountability and better management by providing Legislators and the public with an independent assessment of the government's use of public resources.

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Additional issues highlighted in the Provincial Auditor's *2021 Report–Volume 1* include:

- Chapter 5: Education—Evaluating the Early Learning Intensive Support Program
- Chapter 8: Justice and Attorney General and Corrections, Policing, and Public Safety—Implementing Strategies to Reduce Short-Term Remand in Saskatoon and Surrounding Area
- Chapter 10: Saskatchewan Liquor and Gaming Authority—Regulating Cannabis
- Chapter 11: Saskatoon School Division No. 13—Monitoring Success in Readying Students for Learning in the Primary Grades When Exiting Kindergarten
- Chapter 22: Saskatchewan Health Authority—Providing Timely Access to Mental Health and Addiction Services in Prince Albert and Surrounding Area
- Chapter 31: Water Security Agency—Regulating Drainage
- Others from 24 additional chapters

See accompanying news releases and backgrounders for further details about key topics.

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