May 11, 2012

Honourable Gordie Gosse
Speaker
House of Assembly
Province of Nova Scotia

Dear Sir:

I have the honour to submit herewith my Report to the House of Assembly under Section 18(2) of the Auditor General Act, to be laid before the House in accordance with Section 18(4) of the Auditor General Act.

Respectfully submitted

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Office of the Auditor General

Our Vision

A relevant, valued and independent audit office serving the public interest as the House of Assembly's primary source of assurance on government performance.

Our Mission

To make a significant contribution to enhanced accountability and performance in the provincial public sector.

Our Priorities

Conduct and report audits that provide information to the House of Assembly to assist it in holding government accountable.

Focus our audit efforts on areas of higher risk that impact on the lives of Nova Scotians.

Contribute to a better performing public service with practical recommendations for significant improvements.

Encourage continual improvement in financial reporting by government.

Promote excellence and a professional and supportive workplace at the Office of the Auditor General.

Who We Are and What We Do

The Auditor General is an independent nonpartisan officer of the Legislature, appointed by the House of Assembly for a ten-year term. He or she is responsible to the House for providing independent and objective assessments of the operations of government, the use of public funds, and the integrity of financial reports. The Auditor General helps the House to hold the government to account for its use and stewardship of public funds.

The Auditor General Act establishes the Auditor General's mandate, responsibilities and powers. The Act provides his or her Office with a modern performance audit mandate to examine entities, processes and programs for economy, efficiency and effectiveness and for appropriate use of public funds. It also clarifies which entities are subject to audit by the Office.

The Act stipulates that the Auditor General shall provide an opinion on government's annual consolidated financial statements; provide an opinion on the revenue estimates in the government's annual budget address; and report to the House at least annually on the results of the Office's work under the Act.

The Act provides the Office a mandate to audit all parts of the provincial public sector, including government departments and all agencies, boards, commissions or other bodies responsible to the crown, such as regional school boards and district health authorities, as well as funding recipients external to the provincial public sector. It provides the Auditor General with the authority to require the provision of any documents needed in the performance of his or her duties.

In its work, the Office of the Auditor General is guided by, and complies with, the professional standards established by the Canadian Institute of Chartered Accountants, otherwise known as generally accepted auditing standards. We also seek guidance from other professional bodies and audit-related best practices in other jurisdictions.

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Introduction

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1 Introduction

Introduction

1.1 I am pleased to present my May 2012 Report to the House of Assembly on work completed by my Office in late 2011 and early 2012.

1.2 In the last year I have submitted the following reports.

- My Business Plan for 2011-12, and my Report on Performance for 2010-11 were provided to the Public Accounts Committee on May 9, 2011 and July 12, 2011 respectively.
- My Report on the Province's March 31, 2011 consolidated financial statements, dated July 21, 2011, was tabled with the Public Accounts by the Minister of Finance on July 28, 2011.
- My Report to the House of Assembly on work completed by my Office in the summer and fall of 2011, dated October 28, 2011, was tabled on November 16, 2011.
- My January 2012 Report to the House of Assembly on financial reporting issues, dated January 5, 2012, was tabled on January 18, 2012.
- My Report on the Estimates of Revenue for the fiscal year ended March 31, 2013, dated April 2, 2012, was included with the budget address delivered by the Minister of Finance on April 3, 2012.

1.3 I wish to acknowledge the valuable efforts of my staff who deserve the credit for the work reported here. As well, I wish to acknowledge the cooperation and courtesy we received from staff in departments and agencies during the course of our work.

Common Theme

Lack of Oversight by the Department of Health and Wellness

1.4 This report includes three chapters related to the Department of Health and Wellness: Addiction Services at Annapolis Valley Health, Infection Prevention and Control at Cape Breton District Health Authority and Capital Health, and the Nova Scotia Prescription Monitoring Program.

1.5 During our work on these audits, we noted a significant issue at the Department which was common in two of these audits. The Department's oversight and monitoring of services provided through district health authorities is limited.

1.6 We found the Department is not adequately monitoring infection prevention and control practices in hospitals. The Department does not know whether district health authority infection prevention and control policies are based on best practices or whether districts follow the Department's guidelines.

1.7 We also found oversight of addiction services by the Department is limited. Apart from reviewing wait times, the Department does not monitor compliance with its addiction services standards.

1.8 This is not the first time we have identified issues with Health and Wellness' oversight of district health authorities and programs.

- During our audit of mental health services in June 2010, we noted Departmental oversight was inadequate. There was no monitoring of compliance with mental health standards and we concluded the Department was not fulfilling its legislative requirements under the Health Authorities Act.
- In July 2009, we reported that the Department had not reviewed district health authorities' pandemic preparedness plans.
- In February 2008, we noted the need to update legislation to ensure an adequate accountability structure in the public health system. (At the time of the audit, this fell under Health Promotion and Protection which has since been amalgamated with Health to create the Department of Health and Wellness.)
- In our June 2007 audit of diagnostic imaging equipment, we noted the Department should take a more active role in assuring adequate quality assurance processes are in place for diagnostic imaging equipment throughout the province.

1.9 The Health Authorities Act requires the Minister of Health and Wellness to: *"monitor, measure and evaluate the quality, accessibility and comprehensiveness of health services."*

1.10 Department of Health and Wellness senior management told us that they have plans to improve district accountability to the Department through signed accountability arrangements. However, these have been in process for some time and have not been finalized. The Department should not need separate accountability documents with district health authorities to effectively monitor service provision.

1.11 We believe the Department has a responsibility to ensure appropriate delivery of health services across the province. It has a role to provide guidance as well as direction for the health system to ensure directives are followed, and not only to monitor, but to ensure that weaknesses in service delivery are corrected. This is true regardless of the service delivery mechanism, such as district health authorities.

Chapter Highlights

1.12 This Report presents the results of audits and reviews completed in late 2011 and 2012 at a number of departments and agencies. Where appropriate, we make recommendations for improvements to government operations, processes and controls. Department or agency responses have been included in the appropriate Chapter. We will follow up on the implementation of our recommendations in two years, with the expectation that significant progress will have been made.

Follow-up

Chapter 2 – Follow-up of 2005 to 2009 Performance Audit Recommendations

1.13 The overall implementation rate of recommendations from our performance audits is inadequate. Only 63% of our recommendations from 2005 to 2009 were implemented. We consider there was a failure to implement recommendations still outstanding from our 2005 and 2006 reports. 32 (30%) of 107 recommendations made in 2005 and 33 (30%) of 111 recommendations made in 2006 were not implemented. During the audit, we reviewed information supporting the first Provincial Update on the Auditor General Recommendations which the province issued in fall 2011. We identified 82 errors in the reported statuses. This Update, which was provided to Executive Council, and which was ultimately issued to the public, was inaccurate.

Performance Audits

Chapter 3 – Health and Wellness: Addiction Services at Annapolis Valley Health

1.14 We found addiction services at Annapolis Valley Health are well-managed. Access to services was generally timely and these services covered most program areas we expected. We tested a sample of patient files and found policies were followed in most instances. We did identify improvements which could be made to Annapolis' monitoring of its addiction services and made recommendations to strengthen these processes.

1.15 We found oversight of addiction services by the Department of Health and Wellness is limited. With a few exceptions, district health authorities are not required to provide detailed information on addiction services to Health and Wellness. We found the Department's province-wide addiction services information system was not calculating wait times correctly.

Chapter 4 – Health and Wellness: Infection Prevention and Control at Cape Breton District Health Authority and Capital Health

1.16 Cape Breton District Health Authority has a poor culture of infection prevention and control. Weak infection prevention and control practices may have contributed to a significant *C. difficile* outbreak in Cape Breton hospitals in early 2011. We found Cape Breton's response to the outbreak was ineffective and was hampered by poor practices. Cape Breton District Health Authority's leaders must demonstrate the importance of infection prevention and control by ensuring the District takes immediate steps to address the issues identified by our audit and by Infection Prevention and Control Nova Scotia's outbreak report.

1.17 Our work at Capital Health showed a good understanding of infection prevention and control practices; although we did identify problems and make recommendations for improvement. We tested both Districts' practices for tracking the cleaning and disinfecting of gastro, broncho, and colon scopes. We identified one scope at Capital for which there was no evidence it was disinfected before being returned to use. We also identified two scopes at Cape Breton for which there was no evidence the scopes were cleaned and disinfected between patients. We identified instances in which both Districts used flash sterilization in nonemergency situations which is not acceptable under Canadian standards.

Chapter 5 – Health and Wellness: Nova Scotia Prescription Monitoring Program

1.18 While some aspects of the Nova Scotia Prescription Monitoring Program are effective, there are significant weaknesses in the Program's control and monitoring processes that can allow abuse or misuse of prescription drugs to continue undetected. The Program does not track or monitor the results of warnings pharmacists receive to notify them of potential issues. The Program produces regular reports to assess utilization of monitored drugs and individuals receiving prescriptions from multiple prescribers. However, many situations identified in these reports are not followed up and Program staff do not document details of their review of these reports. We identified many instances in which there is no evidence that appropriate action was taken when potential concerns were identified.

Chapter 6 – Justice: Office of Public Trustee

1.19 The Office of Public Trustee has comprehensive policies for managing client investments and for assisting staff in making health care decisions for their clients. We found the Office managed client investments appropriately. We found a significant weakness in the Office of Public Trustee's processes for collecting client assets; individuals assigned to enter a client's home to identify, assess and collect assets and personal papers are not supervised by Office of Public Trustee staff. The Office of Public Trustee's financial statements provide adequate information to enable users to

evaluate the financial operations of the Office. However the system currently used to record transactions is highly inefficient as a financial accounting system, and there is a risk of inaccurate recording in the financial statements.

Follow-up

2 Follow-up of 2005 to 2009 Performance Audit Recommendations

Summary

The overall implementation rate of our performance audit recommendations is inadequate. Only 63% of the recommendations in our 2005 to 2009 reports were implemented. We consider there was a failure to implement recommendations still outstanding from our 2005 and 2006 reports. 32 of 107 recommendations made in 2005 (30%) and 33 of 111 recommendations made in 2006 (30%) were not implemented. These recommendations related to programs such as special education and fleet management. Government's failure to implement these recommendations constitutes poor management practices and poor accountability to the House.

The Province issued the first Provincial Update on the Auditor General Recommendations in fall 2011. During our review of information supporting the Update, we identified 82 errors in the reported statuses. The number of identified errors means there was a significant deficiency in the reliability of information used to prepare the Update. Information provided to Executive Council and the public was inaccurate. We recommended the system used by departments and agencies to report implementation statuses be updated and that Treasury Board Office implement a quality assurance process to ensure statuses reported in the system are complete and accurate.

We encountered significant difficulties completing this review, particularly from the Department of Education. Information requested to support statuses was not provided on a timely basis. In some cases, information finally provided did not address the issue raised and we had to seek additional support. In addition, there were numerous instances in which there was little or no information in the Tracking Auditor General Recommendations system to support the reported status. Despite the Department's assurances during last year's review that there would be improvements in its implementation rate, we found their rate, at 13%, remained the lowest of all departments.

The implementation rate of the Department of Health and Wellness increased from 36% to 56% since our last review. This is largely due to progress made in addressing recommendations from our 2009 reports, but the implementation rate of recommendations made during our audits of long term care in 2007 and home care in 2008 is 12% and 34% respectively. These implementation rates are insufficient for such significant programs.

Details of all performance audit recommendations from 2005 to 2009, along with their current status, can be found on our website at oag-ns.ca.

2 Follow-up of 2005 to 2009 Performance Audit Recommendations

Background

2.1 Our Office's strategic priorities include serving the House of Assembly, considering the public interest, and improving government performance. We work toward these priorities by providing legislators with the information they need to hold government accountable. We obtain this information primarily by conducting audits which, over time, will cover major activities of government. The results of our audits are detailed in our Reports to the House of Assembly. Each report includes recommendations which we believe provide practical, constructive advice to address issues raised by these audits.

2.2 We follow up the implementation status of these recommendations after two years. We believe two years is sufficient time for auditees to substantively address our recommendations.

2.3 This year we prepared two follow-up chapters. Chapter 6 of our January 2012 Report provided information on the status of recommendations concerning financial reporting and other financial management issues as well as how responsive departments and agencies were in implementing the recommendations from our 2005 to 2008 audits. (There were no financial reporting chapters in our 2009 Reports.) In this Chapter, we report the results of follow-up on the implementation status of the recommendations from our 2005 to 2009 performance audits.

2.4 During this assignment we reviewed government managements' self-assessment of their progress in implementing the outstanding 2005 to 2009 recommendations in Treasury Board Office's Tracking Auditor General Recommendations (TAGR) system. We also asked management to provide supporting information. Our review process focused on whether self-assessments and information provided by management were accurate, reliable and complete. This Chapter includes summary information on implementation status; more detailed information, including specific recommendations, can be found on our website at oag-ns.ca.

Review Objective and Scope

2.5 The objective of this assignment was to assess and report on the implementation status of performance audit recommendations included in reports of the Auditor General from 2005 to 2009.

2.6 Each government department and agency is required by the TAGR Steering Committee to document its self assessment on the implementation of the Office's recommendations recorded in the TAGR system. We reviewed information included in the TAGR system as of October 20, 2011. We understand the attributes that department and agency management use to determine the implementation status of recommendations for this system is consistent with the attributes we used during this assignment.

2.7 We performed additional procedures on those recommendations which government assessed as do not intend to implement or action no longer applicable. We focused on the reasons why government has chosen not to implement these recommendations. If the rationale appeared reasonable, we removed the recommendation from our statistics and will not conduct further follow up work on it.

2.8 Our review of the implementation status was based on representations by department and agency management which we substantiated through interviews and examination of documentation. We performed sufficient work to satisfy ourselves that the implementation status as described by management is plausible in the circumstances. This provides a moderate, not high, level of assurance. Further information on the difference between high and moderate assurance is available in the Canadian Institute of Chartered Accountants (CICA) Handbook, Section 5025 – Standards for Assurance Engagements other than Audits of Financial Statements.

2.9 Our criteria were based on qualitative characteristics of information as described in the CICA Handbook. Management representations on implementation status were assessed against three criteria.

- Accurate and neither overstate nor understate progress
- Reliable and verifiable
- Complete and adequately disclose progress to date

Significant Observations

Provincial Update on the Auditor General Recommendations

Conclusions and summary of observations

For the past three years, we have reported that information in the Tracking Auditor General Recommendations system was both incomplete and inaccurate. We found similar problems this year. As a result of our review, changes were made to the status of 82 recommendations reported in the system. Since information in the system was the source for the first Provincial Update on the Auditor General Recommendations issued in November 2011, the

Update was inaccurate. This is a serious deficiency in accountability to both Executive Council and the general public. We have recommended Treasury Board Office implement a quality assurance process to ensure information reported on the implementation status of recommendations in the Tracking Auditor General Recommendations system is accurate and complete.

2.10 Government has developed a system (Tracking Auditor General Recommendations) to track the implementation status of our recommendations. Oversight of the system is provided by a steering committee which consists of senior management of the Department of Finance, Treasury Board Office, and the Office of Priorities and Planning.

2.11 For the past three years, we have reported that information in the system was both incomplete and inaccurate. We found similar problems this year and identified the following issues.

- The implementation status of recommendations in the system was not accurate. Changes were made to the status of 82 of 510 (16%) recommendations after consultation with staff of departments and agencies. This is a high error rate. Thirty (36%) of these recommendations related to the Department of Health and Wellness (including certain district health authorities), and 16 (19%) recommendations related to the Department of Education (including certain school boards).
- We noted information in the system was missing, incomplete or had not been updated to reflect the current status of the recommendations. This was particularly evident for recommendations assigned to the Department of Education. There were numerous instances in which there was little or no information in the system to support the reported status.

2.12 The system was developed to provide information to government on the implementation status of our recommendations. If the information in the system is inaccurate and incomplete, results reported to senior management in departments is unreliable. The reliability of information is particularly important since government has committed to providing regular updates to the public on the implementation status of our recommendations.

Recommendation 2.1
Treasury Board Office should update the Tracking Auditor General Recommendations system to ensure it is accurate and complete.

Treasury Board Office Response:
We agree that TAGR should be accurate and complete and the TAGR Steering Committee will continue to work with departments and the Office of the Auditor General to help ensure responses to recommendations are tracked and reported appropriately.

2.13 *Provincial update* – In May 2011, government committed to updating Nova Scotians every six months on the progress of implementing our recommendations. On November 9, 2011 the first Provincial Update on the Auditor General Recommendations as at October 31, 2011 was released.

2.14 The Update provides information on the status of recommendations by chapter and department or agency from Reports of the Auditor General issued from January 2009 to May 2011. There is also summary information by department and agency for the 2005 to 2008 calendar years. The Update is prepared from information contained in the Tracking Auditor General Recommendations system.

2.15 Although we did not review or otherwise verify the information provided in this Update, the majority of recommendations in the Update were part of our review process for preparation of this Chapter. We found that the status of 82 recommendations reported in the Update was inaccurate. In our opinion, this is a serious deficiency in accountability to both Executive Council and the general public because the information provided was incorrect and unreliable. Government needs to develop a process to determine the accuracy of the information it is reporting and implement a quality assurance process to ensure information in the Tracking Auditor General Recommendations system, used to prepare the Provincial Update, is accurate and complete.

Recommendation 2.2
Treasury Board Office should implement a quality assurance process to ensure information reported on the implementation status of recommendations in the Tracking Auditor General Recommendations system is accurate and complete.

Treasury Board Office Response:
We do not agree with this recommendation; we do not believe the benefits of an additional quality assurance/audit process outweigh the costs of doing so.

Failure to Implement

Conclusions and summary of observations

We expect to see substantial implementation of our recommendations within two years. The Office issued two reports in each of 2005 and 2006 with a total of 233 recommendations. We determined that 153 (66%) of these recommendations have been implemented. A further 15 (6%) recommendations have been removed from our calculations as they are no longer applicable or the rationale provided for not implementing them appears reasonable. There was a failure to implement 65 (28%) of the recommendations made in 2005 and 2006. Government's failure to correct deficiencies identified in our audits constitutes poor management practice and poor accountability to the House.

2.16 *Failure to implement recommendations from 2005 and 2006* – We expect to see substantial implementation of our recommendations within two years. Government has generally indicated their intention to implement the recommendations made from our audits at the time of their completion.

2.17 The Office issued two reports in each of 2005 and 2006 with a total of 233 recommendations. During this year's review, we determined that 153 (66%) of these recommendations have now been implemented. A further 15 (6%) recommendations have been removed from our calculations as they are no longer applicable or the rationale provided for not implementing them appears reasonable. We consider that there was a failure to implement the remaining 65 (28%) of the recommendations made in 2005 and 2006. 32 (30%) of these related to the 107 recommendations made in our 2005 reports, and 33 (30%) related to the 111 recommendations made in our 2006 reports.

2.18 Appendix 1 at the end of this Chapter provides a complete listing of recommendations from 2005 and 2006 which have not been implemented. The following paragraphs are examples of recommendations and the audit findings which supported them being made.

- In June 2005, we completed an audit of Special Education. During the audit, we attempted to obtain information on services being provided to all special needs students. We recommended the Department of Education and regional school boards should analyze the information needs for Special Education and consider developing a province-wide student information system. This would facilitate performance measurement of the programs provided to students, and assist decision making.

- Our December 2005 report included the results of a review of electronic information security and privacy protection. One objective of the review was to determine if the policies and practices of government regarding information security were appropriate to protect the electronic information in the custody of the government. We recommended a formal security risk analysis be conducted, by department, regarding controls over personal information. We further recommended that all staff with access to personal information be required to sign a confidentiality agreement as a condition of employment. This agreement, which should be reviewed annually, allows management to effect appropriate disciplinary procedures should a breach of confidentiality occur.

- We conducted an audit of the Student Assistance program in 2005. During our examination of the application and assessment process, we noted that factors such as marital status and dependents can complicate the usual simplicity of the assessment process. We recommended an analysis of the risks affecting the Student Assistance program be prepared and appropriate preventative and detective controls be implemented to mitigate these risks, including an effective quality control program.

- In June 2006, we reported the results of an audit at three district health authorities. We again recommended, as we had during a previous audit conducted in 2002, that the Department of Health (now the Department of Health and Wellness) establish and implement a funding formula for funding allocations to the district health authorities. This recommendation was consistent with that made by a consultant engaged by the Department in 2004 to conduct value-for-money assessments at two of the authorities included in the scope of our audit.

- We audited planning and management of highway projects at the Department of Transportation and Public Works (now the Department of Transportation and Infrastructure Renewal) in December 2006. At that time, the Department had recently acquired a bridge management system to maintain inventory and other data. When fully operational, the system was expected to allow the Department to explore the impact of funding options on the overall state of the bridge inventory and present options for the rehabilitation of each structure. We recommended the Department implement the system on a timely basis to assist in prioritizing projects for its annual and long-range plans.

2.19 Of the 22 chapters included in these four Reports, 10 (five each) related to the Departments of Education, and Health and Wellness. One chapter (Student Assistance – Chapter 7, December 2005 Report) was reassigned to the Department of Labour and Advanced Education this year due to the transfer of the student loans program to that Department. Four chapters (two each) related to the Departments of Transportation and Infrastructure Renewal, and Justice. 50 (77%) of the 65 recommendations not implemented to date, and which we now consider as failed to implement, relate to these five departments. The remaining recommendations related to other departments and agencies.

2.20 21 (42%) of these 50 recommendations were made to the Department of Education and certain regional school boards. Since the time of our last review, reported in May 2011, we note that only four of the original 50 recommendations made to the Department and these boards in 2005 and 2006 were implemented. This lack of progress contributed to the Department having the lowest implementation rate of all recommendations made in 2005 and 2006.

2.21 Department of Education senior management advised us they would make it a priority to address our recommendations based on the poor results reported in 2011, and we included this commitment in our May 2011 report. However, our statistics indicate little action was taken on these earlier recommendations. In our view, the Department of Education did not assign priority to this task. The Department continues to ignore earlier recommendations.

2.22 Similarly, since 2011, the Department of Health and Wellness only implemented an additional four of the original 46 recommendations made to the Department and certain district health authorities during 2005 and 2006. This lack of action is contrary

to that promised by the Department after the release of our 2011 report. While there was improvement in implementing recommendations from our 2009 audits, there has been little progress made on older recommendations.

2.23 During this year's review, we found that there has been little or no progress by either the Department of Transportation and Infrastructure Renewal, or the Department of Justice, since our last review in implementing recommendations made during our 2005 and 2006 audits. There was also no progress made by the Department of Labour and Advanced Education in implementing recommendations related to student assistance.

2.24 As time elapses and recommendations fail to be addressed, management is likely to lose track of important issues raised in our audits of programs and services, and changes encouraged by our recommendations may not occur. In addition to missed improvements in existing programs and services as a result of this inaction, government misses the opportunity to incorporate best practices in new or revised programs. Government's failure to correct the deficiencies pointed out in our reports constitutes poor management practice and poor accountability to the House.

Implementation Results – 2005 to 2009

Conclusions and summary of observations

The overall implementation rate for recommendations made in our reports from 2005 to 2009 is 63%. The response from government in implementing our recommendations is inadequate and shows a lack of commitment by government. We encountered significant difficulties in completing our review of the implementation status of recommendations made to the Department of Education and various school boards; numerous changes were made to their initial reported statuses. This situation contributed to the number of corrections needed in the Tracking Auditor General Recommendation system, and also to our conclusion on the inaccuracy of the Provincial Update on the Auditor General Recommendations as at October 31, 2011. Significant improvement is required in implementing the recommendations made during our audits of the Department of Health and Wellness's long-term care and home care programs. Only 10 (27%) of the 37 recommendations made during those audits, which were conducted in 2007 and 2008, have been implemented to date. This response is insufficient for these significant programs.

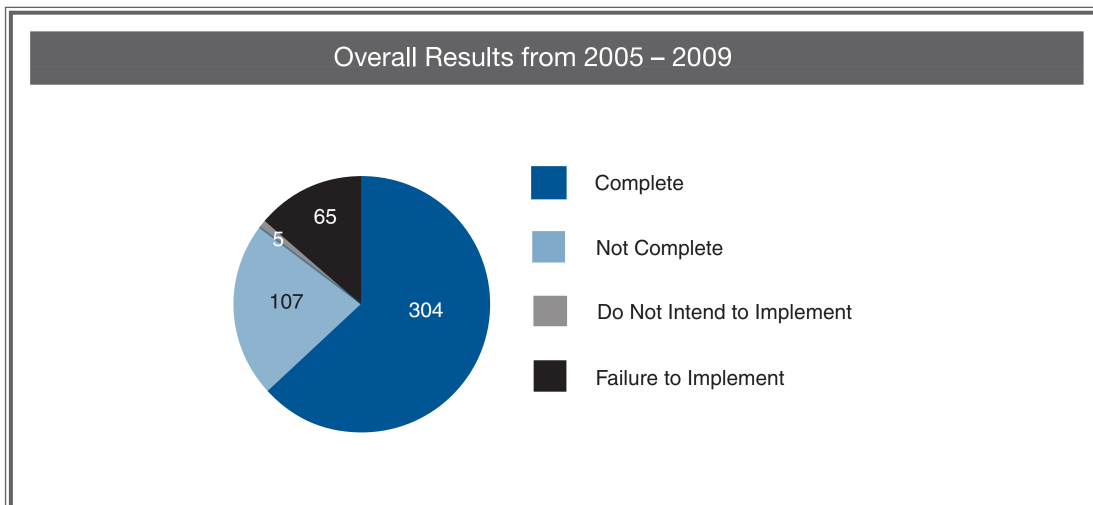
2.25 *Scope of review* – We followed up the status of 481 recommendations made in our reports between 2005 and 2009. Responsibility for certain recommendations on which we reported in May 2011 was reassigned by the TAGR Steering Committee during the year to ensure responsibility to implement the recommendations was assigned to the appropriate department or agency. As a result, some statistics differ from last year.

2.26 *Do not intend to implement or action no longer appropriate* – 28 recommendations were reported to us as do not intend to implement or action no longer appropriate. We reviewed the information provided by government with respect to these recommendations and determined the rationale provided for 20 recommendations was reasonable. These recommendations have been removed from further analysis and statistics. We disagree with government's rationale for not implementing the remaining eight recommendations and believe the findings on which the recommendations were based still exist. Examples of these recommendations are as follows.

- The Pension Regulation Division at the Department of Labour and Advanced Education should implement a process to verify that pension plan assets are prudently invested, and invested in accordance with legislation and the plan's statement of investment policies and procedures.
- Regulations to the Education Act should reflect best practices in the roles and responsibilities of audit committees at school boards.
- The extent of internal audit activity within government (departments and agencies) should be assessed and a plan should be developed to address deficiencies.

2.27 *Overall analysis* – The following exhibits summarize the implementation status of the 481 recommendations made from 2005 to 2009.

Implementation Status	2005 Reports	2006 Reports	2007 Reports	2008 Reports	2009 Reports	Overall
Complete	70%	70%	57%	54%	63%	63%
Not Complete	0%	0%	43%	43%	35%	22%
Do Not Intend to Implement	0%	0%	0%	3%	2%	1%
Failure to Implement	30%	30%	0%	0%	0%	14%
	100%	100%	100%	100%	100%	100%



2.28 The overall implementation rate this year is 63%, an 11% increase over the implementation rate of 52% reported in May 2011. The number of recommendations assessed as do not intend to implement or action no longer appropriate has decreased from the prior year because we re-evaluated government's rationale for not implementing several recommendations and determined it was reasonable. Accordingly, these recommendations have been excluded from our statistics. This has resulted in an improved implementation rate this year. If we had not changed our calculations this year, the implementation rate would have been 61%.

2.29 The overall response from government in implementing recommendations is inadequate. Only 70% of our recommendations in 2005 and 2006 have been implemented. We now consider there was a failure to implement the remaining recommendations in these two years. These statistics show a lack of commitment by government to implement our recommendations.

2.30 The implementation rate for our 2007 recommendations is 57%; 33 recommendations have not been implemented. For 2008, 54% of our recommendations have been implemented; 49 recommendations have not been implemented. Based on the results for 2005 and 2006, we are concerned that many of these recommendations will not be implemented.

2.31 When we make recommendations as a result of our audits, we seek acknowledgement from departments and agencies that they agree with and intend to implement the recommendations. Almost all published responses included in our reports indicate both agreement and intention to implement. We therefore expect to see higher implementation rates than what we have found to date; we also expect to see substantially full implementation within two years.

2.32 *Department and agency analysis 2005 to 2009* – The results by department and agency provide an indication of which organizations have made it a priority to address our recommendations. The following graph shows the implementation rate for those organizations in which we have conducted a significant number of audits, or to which we have made a significant number of recommendations. The Department of Community Services has the highest implementation rate at 85%, while the Department of Education has the lowest rate at 13%.

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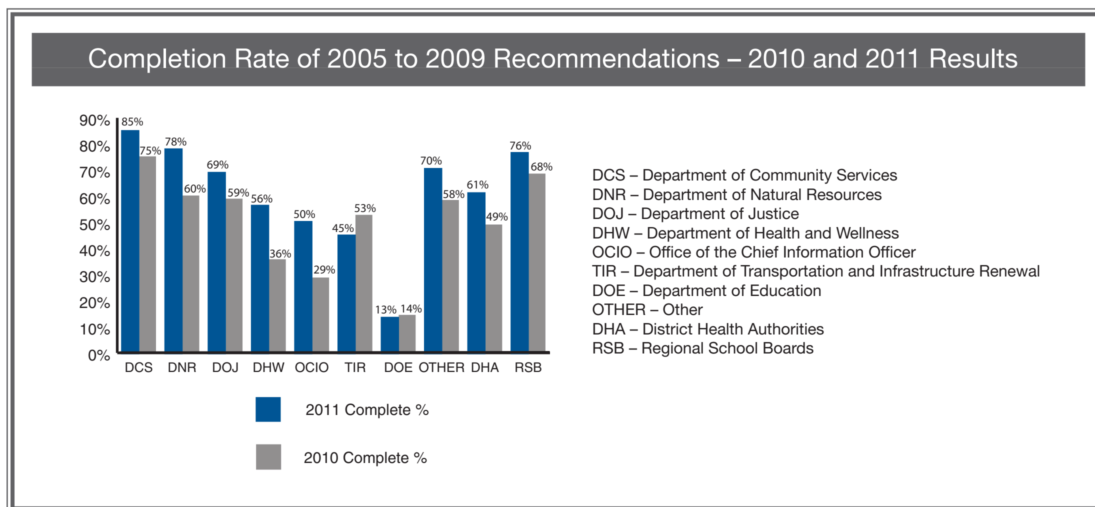

2.33 *Department of Natural Resources* – The implementation rate of recommendations made to the Department of Natural Resources increased to 78% from 60%. However this increase was because three additional recommendations from our 2005 audit of fleet management were implemented during the year. Six recommendations made in 2005 and 2006 are now considered as failed to implement. Overall, the Department made little progress in implementing our audit recommendations during the year.

2.34 *Department of Justice* – The implementation rate of recommendations made to the Department of Justice increased to 69% from 59%. The Department implemented three more recommendations from our 2007 audit of the Maintenance Enforcement Program, bringing the overall implementation rate after four years to 67% on this critical program. Recommendations related to bank accounts and funds transfers in this Program remain to be implemented.

2.35 *Department of Health and Wellness* – After the results of our follow-up of 2005 to 2008 recommendations were reported in May 2011, senior staff of the Department of Health and Wellness contacted our Office with a pledge to improve their implementation rate. The overall implementation rate for the Department increased from 36% to 56% since our last review, a 20% increase.

2.36 The implementation rates for recommendations made in 2005 and 2006 were 80% and 74% respectively. Outstanding recommendations from those years, including those made to district health authorities, we now consider as failed to implement. The implementation rates for the Department on recommendations made in 2007 and 2008 were 35% and 46% respectively. Of the 30 recommendations assigned to the Department from our 2009 reports, 21 (70%) have been fully implemented within two years, including 75% of the recommendations made in our July 2009 special report on pandemic preparedness. We are encouraged by the commitment the Department has shown to implement our recent recommendations but additional effort is required. We urge the Department to pursue implementation of recommendations made in 2007

and 2008, particularly with respect to audits conducted on home care and long term care programs in those years.

2.37 At the time of our audits, the Department's Continuing Care Branch provided access to home care and long term care services. We conducted an audit on aspects of the long term care program in June 2007 and made eight recommendations regarding accountability of service providers and placement decisions. Only 1 (12%) of these recommendations has been implemented. In November 2008, we conducted an audit of the home care program and made 29 recommendations, of which 9 (31%) have been implemented to date. These recommendations relate to client assessment and reassessment and the investigation of complaints. The implementation rate for these audits is insufficient and we consider the Department's efforts in implementing these outstanding recommendations as an indication of its overall commitment to the implementation process.

2.38 *Department of Transportation and Infrastructure Renewal* – The overall implementation rate for the Department is 45% (13 out of 29 recommendations). The Department has failed to implement seven (24%) recommendations made in our June 2005 and December 2006 Reports.

2.39 During last year's review, we concluded that six of the seven (86%) recommendations made in our November 2008 Report concerning public passenger vehicle safety had not been implemented. Since responsibility for this program was transferred to the Department from the Nova Scotia Utility and Review Board in 2011, this rate has not changed.

2.40 *Department of Education* – We encountered significant difficulties in completing our review of the implementation status of recommendations made to the Department of Education and various school boards. Information requested to support statuses, as well as management agreement on changes to statuses, was not provided on a timely basis. In some cases, information finally provided did not address the issue raised and we had to seek additional support. In addition, there were discrepancies between the statues entered into the Tracking Auditor General Recommendations system by the Department and the documentation provided to us by school boards to support the statuses. This resulted in numerous changes made to statuses and contributed to the number of corrections needed in the system, and also to our conclusion on the inaccuracy of the Provincial Update on the Auditor General Recommendations as at October 31, 2011.

2.41 The implementation rate for the Department of Education is 13%. Of the 15 recommendations made in 2005 to 2009 Reports, two recommendations have been implemented, two recommendations will not be implemented, and the Department failed to implement the remaining 11 recommendations.

2.42 Since 2007, only one audit has been conducted at the Department of Education (February 2008 – South Shore Regional School Board). 83% (15 of 18

recommendations) made to the Board have been implemented to date. The Board's response is noteworthy considering the overall lack of attention by the Department of Education to our recommendations to date.

Appendix 1

2005 and 2006 – Failure to Implement Recommendations

June 2005 Recommendations

Chapter 4 – Special Education – Education

4.1 We recommend that all RSBs conduct regular evaluations of Special Education programs with input from all stakeholder groups to serve as a basis for planning and performance reporting.
Annapolis Valley Regional School Board

4.2 We recommend the Department and RSBs analyze information needs for Special Education and consider the development of a Province-wide student information system to accumulate and report data.
Annapolis Valley Regional School Board
Department of Education

4.3 We recommend that the Department of Education require RSBs to prepare a comprehensive annual report on the performance of all major Special Education programs. The annual report should be made available to stakeholders including the Department, parents, and members of the House of Assembly.
Department of Education

4.5 We recommend that government review and update the Education Act and related regulations to ensure that they reflect the current funding environment.
Department of Education

4.7 We recommend that the Department of Education improve its guidance to RSBs regarding accounting for Special Education expenditures to specifically describe which costs can be charged and how they are to be calculated. A direct costing model should be adopted to ensure that all significant Special Education expenditures are being appropriately identified, classified and reported on a consistent basis at all Boards.
Department of Education

Chapter 5 – Pension Administration System (PenFax) – Finance (now assigned to Nova Scotia Pension Agency)

5.1 We recommend that the PSG establish and test an appropriate disaster recovery plan for the PenFax system. This should include service level agreements with entities external to the PSG.
Nova Scotia Pension Agency

5.2 We recommend the establishment of a policy requiring departments to have an appropriate business continuity plan, and that this plan be kept up-to-date. Further, we recommend the establishment of an initiative to undertake the development and implementation of a corporate business continuity planning process.
Emergency Management Office

Chapter 6 – Nova Scotia hospital Information System (NShIS) Project – Health (now Health and Wellness)

6.1 We recommend the disaster recovery plans and procedures be formalized and tested.
Department of Health and Wellness

2005 and 2006 – Failure to Implement Recommendations

Chapter 8 – Fleet Management – Natural Resources and Transportation and Public Works (Transportation and Infrastructure Renewal)

8.1 We recommend that Transportation and Public Works and Natural Resources investigate ways of coordinating their fleet management operations in order to promote economy and efficiency. In doing so, consideration should be given to including fleet operations of other government departments and agencies.
Department of Natural Resources
Department of Transportation and Infrastructure Renewal

8.7 We recommend that Transportation and Public Works and Natural Resources develop a formal fleet maintenance policy and improve existing systems and practices to ensure vehicles are properly maintained. We further recommend that maintenance activities be adequately supported by appropriate documentation.
Department of Transportation and Infrastructure Renewal

8.8 We recommend that Transportation and Public Works and Natural Resources obtain and use information necessary to monitor whether fleet assets are used efficiently and only for authorized purposes.
Department of Transportation and Infrastructure Renewal

8.11 We recommend that the current registration process be reviewed to determine if there is an opportunity to improve the efficiency of registering Provincial vehicles with the Registry of Motor Vehicles.
Department of Transportation and Infrastructure Renewal

8.13 We recommend that Transportation and Public Works and Natural Resources ensure that bulk fuel storage for fleet operations complies with Provincial regulations. Documentation for inspection and maintenance of storage tanks should be improved. Responsibilities for fuel storage should be clearly assigned and communicated.
Department of Natural Resources – vehicle fleet

8.14(2) Environmental site assessments should be performed on all fuel storage sites operated by the Provincial government, and contaminated sites requiring remediation should be remediated in a timely manner.
Department of Natural Resources

8.16 We recommend measures be taken by Transportation and Public Works and Natural Resources to improve controls over fuel expenses and consumption.
Department of Transportation and Infrastructure Renewal

December 2005 Recommendations

Chapter 3 – Consulting Contracts and Service Arrangements

3.1 We recommend that the business need and other planning considerations be adequately documented in the project files to support the initiation and implementation of a project.
Department of Economic and Rural Development and Tourism (former Office of Economic Development)

3.3 We recommend that change control procedures be defined and documented to control changes to projects. Change requests should be handled as described in the change control process.

2005 and 2006 – Failure to Implement Recommendations

Department of Economic and Rural Development and Tourism (former Office of Economic Development and former Department of Tourism, Culture and Heritage)

3.5 We recommend that departments undertake post-completion evaluations to assess project management, consultant performance, and lessons learned to improve future projects. Where the consultants provide a report, the usefulness of the report should be assessed and an action plan documented to address any recommendations.
Department of Economic and Rural Development and Tourism (former Office of Economic Development)

Chapter 4 – Electronic Information Security and Privacy Protection

4.3 We recommend that a government-wide comprehensive security architecture be developed and implemented and that departmental comprehensive security architectures, consistent with the government-wide architecture, be developed and implemented.
Department of Justice

4.4 We recommend that a formal security risk analysis be conducted, by department, regarding personal information. This might appropriately be a part of the development of a security architecture as recommended above.
Department of Justice

4.6 We recommend that all staff with access to personal information be required to read and sign a confidentiality agreement as a condition of employment and that this agreement be renewed annually.
Department of Justice

Chapter 6 – Income Assistance and Child Care Centres – Community Services

6.2(1) We recommend that the Department of Community Services develop formal file documentation standards for its child care centre licensing activities. In addition, efficiency of licensing activities should be increased by eliminating duplication of recordkeeping and more fully utilizing the computerized licensing system. For example, this could be achieved by providing Early Childhood Development Officers with the ability to complete licensing checklists electronically during inspection visits.

Chapter 7 – Student Assistance – Education (now assigned to Department of Labour and Advanced Education)

7.2 (repeated from 2002 audit) We recommend that the Student Assistance Division prepare an annual operational plan to provide a clear link between the overall Departmental goals and priorities and the more specific goals, priorities, and activities of the Branch and Division. The plan should include measurable performance indicators and targets. The Student Assistance Division should report performance in relation to the plan.

7.4 (repeated from 2002 audit) We recommend that the Department perform an analysis of risks affecting the Student Assistance program, and implement appropriate preventive and detective controls. The Department should consider either verifying the income of Student Assistance applicants and supporting persons through electronic comparisons with CRA data and/or establishing a formal, comprehensive audit regime.

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2005 and 2006 – Failure to Implement Recommendations

7.5 We recommend that the Student Assistance Division improve its internal quality control process by implementing risk assessment and internal audit.

7.6 We recommend that the Student Assistance Division establish a formal target for application turnaround time and report achievement.

7.9 (repeated from 2002 audit) We recommend that the Department of Education continue to pursue a Designation Policy for the Student Assistance program.

Chapter 8 – Sport and Recreation Program Area – Office of Health Promotion (now Department of Health and Wellness)

8.9 We recommend the Sport and Recreation program area continue to implement the CIMS system for all grant programs.

June 2006 Recommendations

Chapter 4 – Information Technology and Financial Controls – Community Services

4.2 We recommend the Department review and update its information technology strategic plan to ensure it reflects changes in information technology and continues to meet Department and user needs. We also recommend an annual business or operational plan be prepared for the Information Technology Services section.

4.10 We recommend the Department examine its information technology purchase approval process and evaluate the necessity of having the current number of approvals.

Chapter 6 – Atlantic Provinces Special Education Authority – Education

6.1(2) We recommend that the Nova Scotia Department of Education pursue changes to both the related inter-provincial agreement to ensure they reflect current APSEA operations.
Department of Education

6.2 We recommend that the APSEA Board improve its governance practices as follows:
- more frequent Board meetings; and
- cyclical review of policies to ensure they are current and include important areas such as conflict of interest and a code of conduct.

Atlantic Provinces Special Education Authority

6.6 We recommend Trust Fund Committee members assess their information needs and obtain the required information from management. The APSEA Board should formally consider the current Trust Fund governance structure to determine whether alternate governance arrangements would improve the accountability to donors.
Atlantic Provinces Special Education Authority

6.7 We recommend that APSEA's legislation be modified to include a requirement to report annually to the House of Assembly.
Atlantic Provinces Special Education Authority
Department of Education

2005 and 2006 – Failure to Implement Recommendations

6.8 We recommend that APSEA management and the Board develop performance indicators and measures which include student outcomes, and establish an annual process for reporting progress.
Atlantic Provinces Special Education Authority

6.11 We recommend that APSEA management prepare an annual business plan for approval by the Board.
Atlantic Provinces Special Education Authority

Chapter 7 – Conseil scolaire acadien provincial – Education

7.3 (same as Recommendation 8.4) We recommend that the Department of Education seek Executive Council approval for school board commercial activities as required under Section 64 (A) of the Education Act.
Department of Education

7.4 We recommend that CSAP establish a policy for school-based funds which applies to all schools. This policy should include requirements for appropriate internal controls and monitoring by CSAP's central office.
Conseil scolaire acadien provincial

7.8 We recommend that the DOE, CSAP and RSBs make a concerted effort to consider shared services in order to achieve due regard for economy and efficiency while maintaining the importance of the cultural mandate. CSAP should formally analyze both the cultural factors and costs of sharing versus stand-alone options and attempt to minimize costs when making decisions.
Conseil scolaire acadien provincial
Department of Education

Chapter 8 – Strait Regional School Board – Education

8.3 We recommend that the Department of Education and RSBs establish salary guidance for all non-union staff at Regional School Boards.
Department of Education

8.4 We recommend that the Department of Education seek Executive Council approval for school board commercial activities as required under Section 64 (A) of the Education Act.
Department of Education

8.11 We recommend that SRSB and DOE continue to investigate opportunities for the purchase of fuel from DTPW facilities.
Strait Regional School Board
Department of Education

Chapter 9 – District Health Authorities – Colchester East Hants, Cumberland & Pictou County – Health (now Health and Wellness)

9.2 (repeated from 2002 Report) We recommend that the Department of Health establish and implement a funding formula to rationalize funding allocations to DHAs.
Department of Health

9.3 We recommend that CHA and PCHA develop written policies and procedures requiring periodic monitoring and forecasting. We also recommend that CHA and PCHA financial

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2005 and 2006 – Failure to Implement Recommendations

reports be modified to include a comparison between budget for the year and a current forecast of results to year end, and written analysis of variances.
Cumberland Health Authority
Pictou County Health Authority

9.6 We recommend the DHAs address the recommendations made by the external auditors and the external consultant concerning information systems security.
Pictou County Health Authority

9.9 We recommend implementation of workload measurement systems for better scheduling of nursing resources. We also recommend improvement in the information systems relating to the summary reporting of causes for overtime.
Colchester East Hants Health Authority
Cumberland Health Authority
Pictou County Health Authority

Chapter 10 – Payments to Physicians – Health (now Health and Wellness)

10.4 (repeated from 2003) We recommend that the Department of Health conduct a detailed analysis of the risks and benefits associated with the payment of claims for expired health cards and that appropriate controls and procedures be implemented.

Chapter 11 – Sustainable Timber Supply – Natural Resources

11.5 We recommend the Department regularly report progress towards each of its significant integrated resource management goals and objectives.

11.6 We recommend the Department establish performance measures relating to sustainable forestry on both private and crown land, and report progress towards forest sustainability on a regular basis.

11.9 We recommend the Department annually report balances and financial activity in the special funds it administers.

December 2006 Recommendations

Chapter 4 – Review of Systems to Collect Wait Time Information – Health (now Health and Wellness)

4.3 We recommend that the reporting of wait times for referrals to radiation cancer specialists reflect more comprehensive information such as the cumulative distributions by type of cancer.

4.5 We recommend that the Department of Health's website disclosure of the wait time for MRIs reflect more comprehensive information such as the specific wait times for major types of MRI examinations rather than just a single data point such as the average for all types.

4.9 We recommend implementation of a formal quality control process for wait time data at both the District Health Authorities where the reports originate and the Department of Health.

2005 and 2006 – Failure to Implement Recommendations

Chapter 5 – Correctional Services – Justice

5.1 We recommend Correctional Services develop, implement and report performance measures, indicators and targets for all key programs and services to enable an assessment of the efficiency and effectiveness of the Division.

Chapter 6 – Planning and Management of Highway Projects – Transportation and Public Works (now Transportation and Infrastructure Renewal)

6.3 We recommend that the Department work toward fully implementing the bridge management system on a timely basis. In addition, the Department should adequately address similar information needs for its management of pavement.

Appendix 2

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Community Services						
December 2005 Chapter 6: Income Assistance and Child Care Centres	DCS	10			1	11
June 2006 Chapter 4: Information Technology and Financial Controls	DCS	8			2	10
June 2007 Chapter 6: Regional Housing Authorities	DCS CBIHA MRHA	4 3 3	2			6 3 3
Recommendations		**28** **85%**	**2** **6%**	**0** **0%**	**3** **9%**	**33** **100%**
Department of Natural Resources						
June 2005 Chapter 8: Fleet Management	DNR	14			3	17
June 2006 Chapter 11: Sustainable Timber Supply	DNR	7			3	10
Recommendations		**21** **78%**	**0** **0%**	**0** **0%**	**6** **22%**	**27** **100%**
Department of Justice						
December 2005 Chapter 4: Electronic Information Security and Privacy Protection	DOJ	5			3	8
December 2006 Chapter 5: Correctional Services	DOJ	5			1	6
June 2007 Chapter 5: Maintenance Enforcement Program	DOJ	12	6			18
Recommendations		**22** **69%**	**6** **19%**	**0** **0%**	**4** **12%**	**32** **100%**

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Health and Wellness						
June 2005 Chapter 6: Nova Scotia Hospital information System (NShIS) Project	DHW				1	1
December 2005 Chapter 8: Sport and Recreation Program Area (former Office of Health Promotion)	DHW	8			1	9
June 2006 Chapter 9: District Health Authorities	DHW				1	1
Chapter 10: Payments to Physicians	DHW	5			1	6
December 2006 Chapter 4: Review of Systems to Collect Wait Time Information	DHW	9			3	12
June 2007 Chapter 2: Management of Diagnostic Imaging Equipment	DHW	1	4			5
Chapter 3: Emergency Health Services	DHW	6	4			10
Chapter 4: Long-Term Care - Nursing Homes and Homes for the Aged	DHW	1	7			8
February 2008 Chapter 4: Communicable Disease Prevention and Control (former Department of Health Promotion and Protection)	DHW	12	7			19
November 2008 Chapter 4: Home Care	DHW	9	19	1		29
April 2009 Chapter 2: Audit Committees	DHW		2			2

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Health and Wellness (continued)						
July 2009 Pandemic Preparedness	DHW	21	7			28
Recommendations		**72 56%**	**50 38%**	**1 1%**	**7 5%**	**130 100%**
District Health Authorities						
June 2006 Chapter 9: District Health Authorities	CEHHA CHA PCHA	4 4 3			1 2 3	5 6 6
June 2007 Chapter 2: Management of Diagnostic Imaging Equipment	CBDHA CDHA	6 7	5 5			11 12
July 2009 Pandemic Preparedness	PCHA	1				1
Recommendations		**25 61%**	**10 24%**	**0 0%**	**6 15%**	**41 100%**
Office of the Chief Information Officer						
June 2005 Chapter 5: Pension Administration System (PenFax)	OCIO	1				1
February 2008 Chapter 5: Governance of Information Technology Operations	OCIO	1	5			6
April 2009 Chapter 3: Information Technology Security	OCIO	12	9			21
Recommendations		**14 50%**	**14 50%**	**0 0%**	**0 0%**	**28 100%**
Department of Transportation and Infrastructure Renewal						
June 2005 Chapter 8: Fleet Management	DTIR	6			6	12

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Transportation and Infrastructure Renewal (continued)						
December 2006 Chapter 6: Planning and Management of Highway Projects	DTIR	4			1	5
November 2008 Chapter 6: Public Passenger Vehicle Safety (formerly assigned to Nova Scotia Utility and Review Board)	DTIR	1	6			7
April 2009 Chapter 4: Truck Safety	DTIR	2	3			5
Recommendations		**13** **45%**	**9** **31%**	**0** **0%**	**7** **24%**	**29** **100%**
Department of Education						
June 2005 Chapter 4: Special Education	DOE				4	4
June 2006 Chapter 6: Atlantic Provinces Special Education Authority	DOE	1			2	3
Chapter 7: Conseil scolaire acadien provincial	DOE	1			2	3
Chapter 8: Strait Regional School Board	DOE				3	3
April 2009 Chapter 2: Audit Committees	DOE			2		2
Recommendations		**2** **13%**	**0** **0%**	**2** **13%**	**11** **74%**	**15** **100%**
Regional School Boards						
June 2005 Chapter 4: Special Education	AVRSB	1			2	3
	CCRSB	3				3
June 2006 Chapter 6: Atlantic Provinces Special Education Authority	APSEA	9			5	14

Status of Recommendations by Entity, by Chapter

Regional School Boards (continued)

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
June 2006 Chapter 7: Conseil Scolaire Acadien Provincial	CSAP	4			2	6
Chapter 8: Strait Regional School Board	SRSB	10			1	11
February 2008 Chapter 2: South Shore Regional School Board	SSRSB	15	3			18
Recommendations		**42** **77%**	**3** **5%**	**0** **0%**	**10** **18%**	**55** **100%**

Other Departments and Agencies

Department of Economic and Rural Development and Tourism

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
December 2005 Chapter 3: Consulting Contracts and Service Arrangements (former Office of Economic Development and Department of Tourism, Culture and Heritage)		1 4			3 1	4 5
June 2006 Chapter 5: Nova Scotia Research and Innovation Trust (former Office of Economic Development)		3				3
Subtotal		**8**			**4**	**12**

Department of Environment

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
February 2008 Chapter 3: Environmental Monitoring and Compliance		5	2			7
Subtotal		**5**	**2**			**7**

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Finance						
December 2005 Chapter 3: Consulting Contracts and Service Arrangements		5				5
April 2009 Chapter 5: Follow-up of 2006 Audit Recommendations			1			1
Subtotal		**5**	**1**			**6**
Department of Intergovernmental Affairs						
December 2005 Chapter 3: Consulting Contracts and Service Arrangements		5				5
Subtotal		**5**				**5**
Department of Labour and Advanced Education						
December 2005 Chapter 7: Student Assistance (formerly assigned to Department of Education)		3			5	8
November 2008 Chapter 5: Pension Regulation		2	2	1		5
Subtotal		**5**	**2**	**1**	**5**	**13**
Department of Service Nova Scotia and Municipal Relations						
June 2007 Chapter 5: Maintenance Enforcement Program		1				1
April 2009 Chapter 4: Truck Safety		5	1			6
Subtotal		**6**	**1**			**7**
Emergency Management Office						
June 2005 Chapter 5: Pension Administration System (PenFax)					1	1

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Emergency Management Office (continued)						
July 2009 Pandemic Preparedness			2			2
Subtotal			**2**			**3**
Executive Council Office						
July 2009 Pandemic Preparedness		2				2
Internal Audit Centre						
November 2008 Chapter 3: Internal Audit		4				4
Nova Scotia Community College						
November 2008 Chapter 3: Internal Audit		3	1			4
Nova Scotia Liquor Corporation						
November 2008 Chapter 3: Internal Audit		3				3
Nova Scotia Pension Agency						
June 2005 Chapter 5: Pension Administration System (PenFax)		5			1	6
Public Service Commission						
December 2005 Chapter 3: Consulting Contracts and Service Arrangements		1				1
December 2006 Chapter 3: Audit of HR Application Controls in SAP R/3 System		1				1
Subtotal		**2**				**2**

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Office of Immigration						
June 2008 Phase 1: Economic Stream of the Nova Scotia Nominee Program			1			1
October 2008 Phase 2: Economic Stream of the Nova Scotia Nominee Program			1			1
Subtotal			**2**			**2**
Treasury Board Office						
December 2005 Chapter 3: Consulting Contracts and Service Arrangements		3				3
February 2008 Chapter 5: Governance of Information Technology Operations		1				1
November 2008 Chapter 3: Internal Audit				1		1
April 2009 Chapter 2: Audit Committees		7	3			10
Subtotal		**11**	**3**	**1**		**15**
Other Departments and Agencies Recommendations		**64** **70%**	**14** **16%**	**2** **2%**	**11** **12%**	**91** **100%**
Total Recommendations		**304** **63%**	**107** **22%**	**5** **1%**	**65** **14%**	**481** **100%**

Treasury Board Office Additional Comments

While the Province acknowledges that there is always opportunity for improvement in processes and the accuracy and timeliness of reporting of information, it maintains that it demonstrates a significant level of accountability to both the Executive Council and the general public in its reporting of status of Auditor General Recommendations. The Report of the Auditor General to the Nova Scotia House of Assembly (May 2011) stated *"We performed a review of the self-assessments provided by management and can state that nothing has come to our attention to cause us to believe the representations made by government management are not complete, accurate and reliable"* (Chapter 2, Page 11). The background information obtained to arrive at the opinion was extracted from the TAGR system.

The information reported in TAGR by Departments is at a point in time and represents the information available at that time. The Provincial Update included the following qualifying statement *"the status updates in this report have not been reviewed and could result in some future discrepancies when reviewed by the Auditor General."* The Provincial Update reported the responses as they were reported in the TAGR System, prior to a review by the Auditor General. Changes in the recommendations between the Provincial Update and the AG's Update resulted from discussions with the departments and the Office of the Auditor General. Some of the reported responses changed from Work In Progress to complete, in part due to timing and in part due to AG's office being satisfied that the recommendation has been implemented. Some other responses changed from Complete to Work in Progress due to multiple reasons, including that some components of the recommendation were not fully implemented.

The TAGR Steering Committee has established processes for the tracking and reporting of responses to Auditor General Recommendations. Steps in this process include: record all recommendations released by the Auditor General in the TAGR system; assign each recommendation to the appropriate departments; and assist departments with specific recommendations as requested. The TAGR Steering Committee coordinates the process and ensures timelines are met, as set out by the Audit Committee, and the Auditor General. The TAGR Steering Committee controls and monitors access to the TAGR system; and provide statistics and reporting, as required.

The TAGR Steering Committee provides oversight of initial responses to Auditor General Recommendations (from 2007 onward). The Departments are responsible to ensure all responses are reviewed for completeness and accuracy, and approved by Senior Management prior to their release to the Auditor General. Departments are also responsible for the quality of status updates and follow up reporting in the TAGR system. The TAGR Steering Committee will continue to work with Departments to ensure both responses to recommendations and status updates are complete, accurate, and timely.

Performance Audits

NOVA SCOTIA

3 Health and Wellness: Addiction Services at Annapolis Valley Health

Summary

We found addiction services at Annapolis Valley Health are well-managed. Access to services was generally timely and services covered most program areas we expected. Until recently, Annapolis Valley Health did not have an opiate treatment program; however, this was addressed in October 2011 with the implementation of a new program.

We also found Annapolis has addiction services policies which are based on best practices. We tested a sample of patient files and found these policies were followed in most instances.

We did identify improvements which could be made to Annapolis' monitoring of its addiction services and made recommendations to strengthen these processes. We also found the District does not take adequate steps to ensure the accuracy of all data it enters in the provincial addiction services information system and made recommendations for improvement.

We found oversight of addiction services by the Department of Health and Wellness is limited. In most areas, district health authorities are not required to provide detailed information on addiction services to Health and Wellness. With the exception of wait time monitoring, Health and Wellness has little monitoring of district health authorities' services provided for compliance with provincial standards. Additionally, although Department management told us that the provincial standards must be met, the standards document notes these are voluntary.

Health and Wellness management told us they have plans to improve district accountability to the Department. However, these have been in process for some time and have not been finalized. The Department needs to do more to meet its legislative requirements under the Health Authorities Act.

The Department has a province-wide addiction services information system which all districts use. We found this system was not calculating wait times correctly. The error we identified could overstate wait times and we recommended this be corrected.

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3 Health and Wellness: Addiction Services at Annapolis Valley Health

Background

3.1 District health authorities and the IWK Health Centre are responsible for the delivery of addiction prevention and treatment services to the public. Most districts have a Director of Addiction Services, in one instance, two districts share a Director.

3.2 The role of the Department of Health and Wellness is to develop policy, monitor the provision of services, provide guidance, and to carry out program planning through its Addiction Services Branch.

3.3 Services available in Nova Scotia range from health promotion and prevention for those who do not abuse potentially addictive substances or gamble, to early identification, brief intervention, and treatment for individuals and families who experience problems associated with substance use or gambling.

3.4 In 2002, the Addiction Services Standards and Best Practices (standards) were released; these were updated in March 2005. Another update was completed in September 2011. However Health and Wellness' senior leadership group had not reviewed these revisions when this report was written. These standards were developed through consultation with various levels of addiction services staff from all districts and the Department of Health and Wellness.

3.5 Some aspects of addiction services pose significant challenges. Often people in need of services do not seek help, or those who do seek services experience relapses and require further assistance.

Audit Objectives and Scope

3.6 In late 2011, we completed a performance audit of addiction services at Annapolis Valley Health (Annapolis). We wanted to determine whether Annapolis is doing an adequate job of ensuring addiction services are available in a timely manner and ensuring services address the needs of the community. We also examined the Department of Health and Wellness' oversight of province-wide addiction services.

3.7 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

3.8 The objectives of this audit were to assess:

- the adequacy of the Department's oversight and whether it has processes to hold Annapolis accountable for addiction services;
- whether the Department uses its addiction services information system (ASsist) to assess standards across the province;
- whether Annapolis has timely access to addiction services and calculates wait time information consistently and accurately;
- whether Annapolis has adequate processes and policies to provide consistent and adequate addiction services, complies with those policies, and assesses and monitors its performance;
- whether Annapolis meets program goals through its education programs for high-risk clients and has appropriately trained addiction services staff;
- whether the Department and Annapolis ensure available resources are used to best meet community needs; and
- whether the Department and Annapolis have appropriate processes to communicate with the public and have adequate information readily available regarding addiction services.

3.9 Certain audit criteria for this engagement were derived from Health and Wellness' Addiction Services Standards and Best Practices as well as Accreditation Canada Qmentum Standards, while others were developed by our Office. All criteria were discussed with, and accepted as appropriate by, senior management at Health and Wellness and Annapolis Valley Health.

3.10 Our audit approach included an examination of the addiction services standards, legislation, addiction services records, and other relevant documents. We tested compliance with selected standards and conducted interviews with management and staff. Our work did not address the quality of addiction services offered in Annapolis, nor did we attempt to assess effectiveness of those services. Our audit period covered April 1, 2009 to October 1, 2011.

3.11 Our work at Annapolis focused on three primary addiction programs: community based services – the largest program, withdrawal management – services for those in most urgent need, and the structured treatment program – a longer, more intensive program.

Significant Audit Observations

Departmental Oversight

Conclusions and summary of observations

The Department of Health and Wellness' oversight of addiction services is not adequate. With the exception of wait time monitoring, Health and Wellness has little monitoring of district health authorities' services provided for compliance with provincial standards. Additionally, while Department management told us that addiction standards must be complied with, the standards document notes these are voluntary. Health and Wellness is responsible for overseeing health care in Nova Scotia. The Department needs to do more to effectively monitor and evaluate district health authority services and to meet its legislative responsibilities.

3.12 *Background* – In 2000, the Health Authorities Act established the district health authorities. Each district health authority has responsibilities that include planning, managing and delivering health services such as acute care, mental health and addictions.

3.13 Section 60(c) of the Act requires the Minister of Health and Wellness to: *"monitor, measure and evaluate the quality, accessibility and comprehensiveness of health services."*

3.14 *Reporting against addiction services standards* – We expected Health and Wellness would have a well-established process to ensure each district assesses its performance against provincial addiction services standards. We also expected Health and Wellness staff would review those assessments as part of the Department's monitoring of addiction services across Nova Scotia.

3.15 There is little evidence that Health and Wellness staff reviewed or assessed Annapolis Valley Health's addiction services beyond a review of wait times data. Department management told us that they meet regularly with the district health authority directors to discuss addiction services across the province; they believe these meetings provide sufficient information.

3.16 Although Department management said that they require districts to comply with addiction services standards, the standards are marked as voluntary and the Department does little to assess compliance with these standards. We found the district health authorities are generally not required to provide regular reports to Health and Wellness regarding addiction services.

3.17 Health and Wellness management told us there is a plan to address this issue through an overall accountability framework for the district health authorities. This has been ongoing for more than a year and had not been finalized when this report was written.

3.18 The Department should not need to establish a separate accountability framework with districts to effectively monitor service provision. The Health Authorities Act tasks the Minister, and thus the Department, with measuring, monitoring and evaluating services. Since services are delivered through districts in Nova Scotia, Health and Wellness needs to more closely monitor the district health authorities in order to meet its legislative requirements.

Recommendation 3.1
The Department of Health and Wellness should determine its information requirements to effectively monitor the district health authorities' provision of addiction services and fulfill its legislative requirements. Districts should be required to provide regular reports to the Department.

Department of Health and Wellness Response:
DHW agrees with this recommendation and will start the process of measuring and monitoring of standards with the implementation of new and revised standards in 2012-13. DHW will require the DHAs/IWK to complete a self-assessment template one-year post implementation of standards where data already exists. DHW anticipates that enhancements to ASsist and/or additional technology will be required to collect the monitoring data for some standards. DHW is currently examining technological solutions by identifying business requirements for clinical decision-making, program planning, and monitoring (e-Health Solutions project). A high level project plan and cost/resource plan to implement the recommended solution is expected to be complete by March 2013. DHW is also preparing a Quality Framework for Addiction Services that will serve as a resource for the planning and implementation of quality activities, including the monitoring of addiction services in the DHAs/IWK. This Framework is expected to be completed in 2012-13.

Recommendation 3.2
The Department of Health and Wellness should determine whether its addiction services standards are mandatory for all district health authorities and if so, communicate this to the districts.

Department of Health and Wellness Response:
DHW agrees with this recommendation and notes that Section 19 (a) (iii) of the Health Authorities Act states: The objects of a district health authority are (a) to govern, plan, manage, monitor, evaluate and deliver health services in a health district in accordance with this Act and any other enactment in order to (iii) meet the needs of the health district, having regard to policies, directives and standards established pursuant to this Act. In addition Section 60 states: In addition to the other duties contained in this Act, the Minister shall (b) develop or ensure the development of standards for the delivery of health services.

The standards manual will be revised to note that standards are mandatory. The DHAs/IWK's responsibilities relating to policy and standards, as outlined in the Health

Authorities Act, will be formally communicated to the DHAs/IWK when the new standards for concurrent disorders and prevention and health promotion and revised standards for community-based services are published. DHW anticipates the standards will be published in 2012-13.

3.19 *Problems with standards* – When we reviewed the provincial addiction services standards, we found serious deficiencies. Many standards are poorly written and exclude part of the addiction services population. For example, standards require that 80% of people be seen within five days of first contact for withdrawal management clients. The standards fail to address the remaining 20%. These individuals could experience significant wait times or even not receive service and the standards would still be met. Additionally, many standards are either not measurable or there is no data collected which would allow measurement. Of the 88 standards in the most recent update (pending Health and Wellness senior management approval), we found only 19 which can be measured through the data already in ASsist.

Recommendation 3.3
The Department of Health and Wellness should revise its addiction services standards so that standards are measurable where possible.

Department of Health and Wellness Response:
DHW agrees with this recommendation and is in the process of seeking Departmental approval for new standards for concurrent disorders and prevention and health promotion and revised standards for community-based services. Each standard includes an indicator to facilitate measurement. DHW will support DHAs/IWK with implementation and monitoring by providing DHAs/IWK with tools to measure and monitor standards. The e-Health Solutions project will set the requirements for a new information system using the new and revised standards. DHW is planning to begin the process of updating the standards for withdrawal management, structured treatment, and methadone maintenance in September 2012. This work should be complete in 2013-14.

Recommendation 3.4
The Department of Health and Wellness should require district health authorities to collect the data needed to measure standards.

Department of Health and Wellness Response:
DHW agrees with this recommendation. DHW will require the DHAs/IWK to monitor, collect data, and report on standards where possible. DHW will support DHAs/IWK with implementation and monitoring by providing DHAs/IWK with tools to measure and monitor standards. The e-Health Solutions project will set the requirements for a new information system which will assist the DHAs/IWK in collecting the data needed to measure standards. DHW is planning to begin the process of updating the standards for withdrawal management, structured treatment, and methadone maintenance in September 2012. This work should be complete by 2013-14.

Recommendation 3.5
The Department of Health and Wellness should revise addiction standards to address the entire population seeking services.

Department of Health and Wellness Response:
DHW agrees with this recommend and is in the process of revising standards to ensure they address the entire population seeking services. Departmental approval for new standards for concurrent disorders and prevention and health promotion and revised standards for community-based services is anticipated in 2012-13. DHW is planning to begin the process of updating the standards for withdrawal management, structured treatment, and methadone maintenance in September 2012. This work should be complete by 2013-14. Each standard will include the entire population seeking services. DHW will support DHAs/IWK with implementation and monitoring by providing DHAs/IWK with tools to measure and monitor standards.

Access to Services and Wait Times

Conclusions and summary of observations

Access to addiction services at Annapolis Valley Health was generally timely and services covered most program areas we expected. When we started our audit, Annapolis did not have an opiate treatment program. This has since been addressed with a new program which began in October 2011. We also found that 89% of the 2,828 clients on the wait list for addiction services were seen within the timeframe established by provincial wait time standards. We found that wait times were consistently calculated. However, we found an error in the Department of Health and Wellness' calculations which could be artificially inflating wait times.

3.20 *Adequacy of services* – Based on the population it serves, Annapolis has identified the services needed and for the most part, those services were provided during our audit period. Areas in which there were potential gaps in services are discussed below. We also found services were provided on a timely basis with waits for appointments falling within provincial wait time standards for the majority of patients.

3.21 *Service gaps* – When we began our audit, we noted two gaps in services.

- Withdrawal management program closure for two weeks in the summer to allow for staff vacations
- Lack of an opiate treatment program

3.22 The closure of the withdrawal management facility each summer is coordinated over a six-week period with South Shore Health and South West Health to ensure they are open at this time. This allows patients to access services in a crisis situation,

although not as close to home as typically available. This is a reasonable approach to addressing this issue and minimizing the impact on patients.

3.23 A new opiate treatment program was introduced in October 2011. Annapolis management recognized that the number of people requiring services for opiate dependency was increasing and that the level of service in Annapolis was not adequate. Clients were able to obtain individual counseling and methadone for short-term withdrawal management, but there was no long-term methadone treatment program offered.

3.24 Annapolis addiction services management told us that one of the challenges of a traditional methadone treatment program is that it is a long-term treatment. Most of these traditional programs do not have significant turnover of clients, resulting in long wait times for new clients.

3.25 Annapolis addiction services staff examined the issues around traditional treatment programs for opiate addiction through stakeholder consultation and other research. Staff developed an opiate replacement treatment program which they believe will address the shortcomings of traditional methadone treatment programs. This program will engage family physicians to prescribe methadone once a client has been stabilized in the core program. Addiction services staff plan to provide regular support to family physicians by providing counseling and urine screening for clients. At the time this Chapter was written, the District was still implementing its new program.

3.26 *Wait time calculations* – Health and Wellness' addiction services information system (ASsist) has a field to record the date service was first offered to a patient (service first available) and another field to record the date when service was first received. If a patient cancels or declines the initial appointment time, these two dates will be different. Annapolis management told us that addiction patients sometimes refuse the first available appointment; for example, a patient may not be in a position to enter a full-time treatment program due to work or family responsibilities.

3.27 When patients decline appointments, this presents challenges in calculating accurate wait times. Health and Wellness management told us the Department removes any situations in which a client refuses service from its wait time calculations. However, when we recalculated addiction services wait times, we found that clients refusing service were still included. Although the Department used a consistent approach to calculating wait times, it used the wrong data. Department management were not aware of this error in wait time calculations; they thought these clients were excluded. This could overstate addiction services wait times.

Recommendation 3.6
The Department of Health and Wellness should verify that its wait time calculations for addiction services are accurate.

Department of Health and Wellness Response:
DHW agrees with this recommendation and is working on an e-Health solution to create a query in ASsist to ensure wait times for addiction services are accurate. The new wait time query is anticipated to be ready by September 2012. The reporting of wait times will exclude clients who decline first available service and will use the program registration date to ensure consistency with other program areas, in particular mental health community-based services wait times, which are measured based on the date the patient first received services.

3.28 We found Annapolis staff did not consistently complete the field to record the date when service was first offered. We identified 226 of 1,760 cases in which the service first available date was either not entered, or was entered incorrectly. This represents almost 13% of the population of clients waiting. This field is intended to provide districts with meaningful information regarding system readiness and should be captured accurately.

Recommendation 3.7
The Department of Health and Wellness should require district health authorities to implement processes to ensure all fields in the ASsist system are completed accurately.

Department of Health and Wellness Response:
DHW agrees with the recommendation and will continue to require DHAs/IWK to complete the field in ASsist related to the services first available date. A Quality Framework being prepared for Addiction Services will serve as a resource for the planning and implementation of quality activities, including the quality of data entry into ASsist.

3.29 *Wait times* – We reviewed ASsist data to determine how quickly clients can access addiction services in Annapolis. We found the majority (89%) of the 2,828 clients on the waitlist were seen within provincial wait time standards.

- Emergency Priority, to be seen the same day – Of two clients deemed emergency priority, only one met this standard. The other client was seen the following day.
- Urgent Priority, to be seen within one week – 7% or 36 of 512 urgent priority clients were not seen within one week and therefore did not meet the wait time standard.
- General Priority, to be seen within three weeks – 12% or 271 of 2,314 general priority clients did not meet the wait time standard. These 271 clients waited up to a maximum of 17 weeks for service.

3.30 *Lack of provincial intake and wait lists for withdrawal management* – During our audit, we were informed that withdrawal management clients can contact more than one program location across the province to be waitlisted for services. Since there

is no province-wide intake for addiction services, the client could call each location across Nova Scotia and be added to the waitlist for that area. The details of the patient's intake are available in ASsist, as is information noting when a patient receives services. However, if staff are not checking ASsist to determine whether a patient has already received services, time could be spent trying to contact a patient who has already received service elsewhere. Additionally, a client may begin a program in one district and leave that withdrawal management program in order to start service in a district closer to home.

3.31 These issues could be avoided with a single provincial intake and wait list system. Patients could contact a single intake line and be placed on a common wait list. This would provide a more accurate picture of the total number of clients waiting for services as well as reduce delays experienced when staff take time to try and contact a client only to find out that client has already received service.

Recommendation 3.8
The Department of Health and Wellness should implement a single province-wide intake and wait list for withdrawal management programs.

Department of Health and Wellness Response:
DHW disagrees with this recommendation. To date, the DHAs/IWK and clients have not identified this as issue. ASsist is a provincial client information system that clinicians utilize to complete intakes for withdrawal management programs. This information can be viewed by all intake workers across the province. DHW, in consultation with the DHAs/IWK, will examine how best withdrawal management services be utilized across the province. DHW agrees in principle to efficient and effective use of in-patient withdrawal management services and believes that clients should have access to quality withdrawal management services and supports while following the principle that withdrawal management services should be as close to the client's community of residence as possible. DHW will consider this recommended solution among other evidence-based options. The business requirements will be examined through the e-Health Solutions project. A high level project plan and cost/resource plan to implement the recommended solution is expected to be complete by March 2013.

Annapolis Valley Health Response:
AVH disagrees with this recommendation. We do support better coordination amongst DHAs to ensure a seamless approach across the continuum of services. ASsist, a provincial client information system for addiction services, should support appropriate coordination of intakes and wait lists for withdrawal management programs province-wide. AVH will work with DHW and other DHAs/IWK to help ensure the efficient and effective use of these programs.

3.32 *Needs assessment* – Annapolis Valley Health completed a community needs assessment in 2009. Management told us this information was used to plan services for Annapolis. However we found there was no clear evidence linking the services offered to the needs assessment, although we did not note any obvious gaps when we

reviewed the needs assessment and considered services offered. One exception was opiate treatment which, as discussed earlier, was addressed in the fall of 2011. While there were no obvious gaps in service, it would be useful for Annapolis to clearly link its services with community needs.

Recommendation 3.9
Annapolis Valley Health should link its assessment of community needs to the addiction services it delivers.

Department of Health and Wellness Response:
DHW agrees with this recommendation and will work with the DHAs/IWK to implement a needs-based approach to planning to ensure a continuum of addiction services and supports. DHW anticipates receiving needs-based planning tools from a national Drug Treatment Funding Program (DTFP) project in 2013-14. The needs-based planning tool will be utilized in the 2014-15 business planning process.

Annapolis Valley Health Response:
AVH agrees with this recommendation and will work with DHW and other DHAs/IWK to implement a needs-based approach to planning to ensure a continuum of addiction services and supports. It is our understanding that needs-based planning tools will be adopted by DHW in the 2014-15 Business Planning Process.

Provision of Addiction Services

Conclusions and summary of observations

We found that Annapolis Valley Health's addiction services guidelines are evidence-based and were developed using best practices, although we did find some minor inconsistencies with provincial standards. We tested intake and assessment files at Annapolis and found overall compliance with policies.

3.33 *Policies* – Prior to 2007, addiction services in Annapolis Valley were shared with South Shore Health and South West Health. In 2007, this model changed and each district had its own addiction services. Eventually, Annapolis developed its own policies for addiction services. Although some of the new policies have minor inconsistencies with provincial standards, the District followed an appropriate process and selected policies which are evidence-based and reflect best practices. Accordingly, we concluded Annapolis' addiction policies are reasonable and appropriate. This further illustrates the need for the Department of Health and Wellness to review and revise its addiction standards, to help ensure district health authority policies are consistent with overall provincial direction.

3.34 *Testing* – We tested the criteria used for intake and assessment of clients for the three programs we audited at Annapolis: structured treatment, withdrawal management

and community based services. We found the files tested were generally complete, supported the decisions made, and were generally compliant with policies.

3.35 *Intakes* – We tested 60 intake files. 56 of the 60 files tested, or 93% met all standards.

3.36 *Assessments* – We tested 20 assessments for each of the programs we audited. Eight files were missing information which should have been collected during client assessment.

- Structured treatment – One file had an outdated assessment and the assessment in one file was not dated.
- Withdrawal management – Three files had no notes on the withdrawal or intoxication level of the client.
- Community based services – One file did not have a signed consent to treatment form. Another file did not have a complete family history and one file had no information on the client's mental status.

Recommendation 3.10
Annapolis Valley Health should implement quality assurance processes, such as file checklists, to ensure client files include all necessary information.

Department of Health and Wellness Response:
DHW agrees with this recommendation and will continue to work with the DHAs/IWK to ensure data quality. A Quality Framework being prepared for Addiction Services will serve as a resource for the planning and implementation of quality activities, including ensuring client files include all necessary information and documentation of decisions regarding client priority. This Framework is expected to be completed in 2012-13.

Annapolis Valley Health Response:
AVH agrees with this recommendation and will continue to work with DHW and other DHAs/IWK to ensure data quality. A Quality Framework being prepared for Addiction Services by DHW will serve as a resource for the planning and implementation of quality activities, including ensuring client files include all necessary information and documentation of decisions regarding client priority. This Framework is expected to be completed in 2012-13.

Performance Monitoring of Addiction Services

Conclusions and summary of observations

Overall, Annapolis made efforts to assess the performance of its addiction services programs, but can improve the adequacy of these assessments. Annapolis measures the quality of its addiction services by comparing against provincial standards. Performance is

assessed through client chart audits and results are reported in the District's annual report. We found the chart audits were not sufficient to fully assess whether standards were met; we also found there were no chart audits completed in 2009 or 2010. Additionally, although clients participating in structured treatment and nicotine programs are monitored, there is no monitoring of clients who participate in Annapolis' other programs.

3.37 *Program objectives* – Management told us they use the provincial standards as general goals regarding the services provided. Annapolis' addiction services annual report provides information on its performance against some of those standards.

3.38 Annapolis monitors compliance with standards through client chart audits. Chart audits involve assessing the information in client files and the addiction services information system to determine whether standards have been met. Management told us they planned to complete chart audits annually. However, we found chart audits had been completed for 2008 and 2011, but not for 2009 or 2010.

3.39 We also noted that those audits which were completed were based on a sample of around 40 charts. Many of the addiction standards are written as a percentage of the population. For example, 80% of people will receive services within a certain timeframe. In these instances, a large statistical sample would be required to accurately assess whether the standards were met. However, a smaller sample such as Annapolis used can still be effective to identify areas for improvement.

3.40 Management told us that they implemented a number of new processes and guidelines to address the findings from the 2008 chart audits. For instance they identified that only 55% of files tested had completed assessments. They created a new assessment policy designed to ensure assessments were completed, but the 2011 results did not show any improvement. We acknowledge that Annapolis has taken steps to assess its addiction services and to make improvements where needed; however, further work is necessary to fully address these issues.

Recommendation 3.11
Annapolis Valley Health should determine whether annual chart audits are required and if so, these audits should be completed on schedule.

Department of Health and Wellness Response:
DHW agrees with this recommendation. DHW recognizes that both the provincial standards for Addiction Services and Accreditation Canada address chart audits. A Quality Framework being prepared for Addiction Services will serve as a resource for the planning and implementation of quality activities, including regular chart audits. This Framework is expected to be completed in 2012-13.

Annapolis Valley Health Response:
AVH agrees with this recommendation. AVH will work with DHW and other DHAs/IWK to determine the role of chart audits in an overall quality framework for addiction services. A Quality Framework being prepared for Addiction Services by DHW will serve as a

resource for the planning and implementation of quality activities, including processes to ensure improvements identified through chart audits. This Framework is expected to be completed in 2012-13.

Recommendation 3.12
Annapolis Valley Health should establish processes to ensure improvements identified through chart audits are implemented.

Department of Health and Wellness Response:
DHW agrees with this recommendation. A Quality Framework being prepared for Addiction Services will serve as a resource for the planning and implementation of quality activities, including processes to ensure improvements identified through chart audits. This Framework is expected to be completed in 2012-13.

Annapolis Valley Health Response:
AVH agrees with this recommendation. A Quality Framework being prepared for Addiction Services by DHW will serve as a resource for the planning and implementation of quality activities, including processes to ensure improvements identified through chart audits. This Framework is expected to be completed in 2012-13.

3.41 *Program Monitoring* – Annapolis Valley Health has an outside agency that performs outcome monitoring for its structured treatment and nicotine programs. This monitoring includes information on current use of addictive substances, changes in lifestyle since the program, and the client's overall impressions of the program. There is currently no outcome monitoring, or other assessment, for other programs at Annapolis. Failure to monitor programs means Annapolis cannot know whether its programs are effective. While we understand outcome monitoring can be difficult, continuing to spend resources on services which may not be achieving the expected outcomes is not appropriate.

Recommendation 3.13
Annapolis Valley Health should implement outcome monitoring for all of its addiction services programs.

Department of Health and Wellness Response:
DHW agrees with this recommendation and will work with the DHAs/IWK to coordinate a common approach to outcome monitoring. A Quality Framework being prepared for Addiction Services will serve as a resource for the planning and implementation of quality activities, including outcome monitoring. This Framework is expected to be completed in 2012-13.

Annapolis Valley Health Response:
AVH agrees with this recommendation and will work with the DHW to develop and coordinate a common approach to outcome monitoring across all DHAs/IWK.

Communication and Education

Conclusions and summary of observations

Both Annapolis Valley Health and the Department of Health and Wellness have appropriate processes to communicate with the public regarding addiction services, such as websites, brochures and workshops. The Department also works closely with Annapolis on joint initiatives to raise awareness of addictions. Annapolis adequately monitors and evaluates its educational programs through participant feedback and program evaluation, but we were unable to determine if this feedback results in program changes. Annapolis has clearly documented the education and training requirements for addiction services staff.

3.42 *Communication* – Annapolis uses a variety of approaches to make information available to potential clients, community members and organizations. Tools include the District website, the Department of Health and Wellness' website, brochures and fact sheets at district buildings, media awareness campaigns, workshops and groups. We noted several initiatives in which Health and Wellness and Annapolis are working together to raise awareness of addiction services.

3.43 Annapolis offers client and public education programs with the goal of building local skills, understanding and awareness of addictions. Staff monitor and evaluate these programs through participant feedback and program evaluations. Management told us that program evaluations are reviewed and programming is updated as required, but could provide no evidence linking feedback received with changes made. Such linkages are useful to provide management with details showing how programs develop over time and to provide a history of what has not worked well.

3.44 *Staff training* – Addiction services staff education and training requirements are clearly documented. Management monitor specific addiction training requirements to ensure staff stay current, and began monitoring other training such as first aid and CPR in fall 2011.

Department of Health and Wellness Additional Comments

The Department appreciates the thorough review by the Auditor General on addiction services in the Annapolis Valley. The Department agrees with most of the recommendations pertaining to the Department and recognizes the importance of accountability in its relationship with the DHAs. Over the next year, the Department will develop and enhance existing measures for monitoring and evaluating the districts' compliance with standards of care and Department expectations.

4 Health and Wellness: Infection Prevention and Control at Cape Breton District Health Authority and Capital Health

NOVA SCOTIA

Summary

Cape Breton District Health Authority has a poor culture of infection prevention and control; the District lacks appropriate infection prevention and control practices. Management need to raise awareness of the importance of best practices and take steps to ensure staff follow these practices. Our work at Capital Health showed a good understanding of infection prevention and control practices; although we did identify problems and make recommendations for improvement.

Poor infection prevention and control practices may have contributed to a significant *C. difficile* outbreak in Cape Breton hospitals in 2011. We found Cape Breton's response to the outbreak was ineffective and was hampered by poor infection prevention and control practices. Infection Prevention and Control Nova Scotia (IPCNS) at the Department of Health and Wellness was not notified until the District-wide outbreak was declared, almost a month after the initial unit outbreak was identified. While districts are not required to inform IPCNS of outbreaks, we have recommended changes to ensure the Department's experts are aware when outbreaks occur. Once IPCNS staff arrived in the District to assist with managing the outbreak, they identified many basic infection prevention and control practices which were not being followed. IPCNS found the failure to follow appropriate practices contributed to the first outbreak. IPCNS also told us that Cape Breton returned to some of its old practices and IPCNS noted these may have contributed to the second outbreak in late 2011.

Reports on Cape Breton's first *C. difficile* outbreak found that hand hygiene practices needed improvement. During our work at the District, we found that hand hygiene audits were infrequent and based on small samples. We also found that infection control practitioners at Cape Breton spend little time visiting patient areas in the hospital or monitoring infection control practices in the District. The manager of infection prevention and control had additional job responsibilities and was not dedicated to this function.

Management at Cape Breton failed to ensure adequate infection prevention and control practices were followed. Cape Breton District Health Authority's leaders must demonstrate the importance of infection prevention and control by ensuring the District takes immediate steps to address the issues identified by our audit and by the IPCNS outbreak report.

Our testing of cleaning and disinfecting practices for gastro, broncho, and colon scopes identified significant problems with both District's practices. Capital had significant gaps in its process to track and record disinfecting procedures; staff were not verifying that the

disinfecting machines completed their cycles. This could result in equipment which is not adequately disinfected between patients. We identified one scope for which there was no evidence of appropriate disinfecting before use on the next patient. At Cape Breton, there was no evidence that two scopes we tested were properly cleaned and disinfected before being used on the next patient.

Additionally, we identified serious problems with the use of flash sterilization (quick sterilization at or near the point of use) at both Districts. This form of sterilizing surgical instruments should only be used in emergency situations. Capital Health regularly uses flash sterilization to compensate for either a lack of surgical instruments or over-scheduling of surgeries. Prior to our audit, Cape Breton did not maintain any records of flash sterilization; these are required under Canadian standards. The District began keeping records when we started audit fieldwork. We tested the records which were available and found Cape Breton was also using flash sterilization in nonemergency situations.

Three years after establishing Infection Prevention and Control Nova Scotia, the Department of Health and Wellness is not adequately monitoring infection prevention and control practices in Nova Scotia hospitals. IPCNS is not sufficiently staffed to allow implementation of its objectives for infection prevention and control in the province. There is no provincial surveillance system for hospital acquired infections. Without monitoring it is impossible to hold the districts accountable and to ensure consistent infection prevention and control practices across the province.

NOVA SCOTIA

4 Health and Wellness: Infection Prevention and Control at Cape Breton District Health Authority and Capital Health

Background

4.1 Infection prevention and control in hospitals is an important component to ensuring safe and appropriate health care for all Nova Scotians. Hospital or health care acquired infections are infections that a patient acquires while in a health care facility being treated for some other condition. Some of these infections are easily spread through a hospital. Examples of common hospital acquired infections include *C. difficile*, MRSA, VRE and SRI (influenza, colds, pneumonia, and others). These can all be spread through contact with someone who carries the disease, an infected person, or with a contaminated surface.

4.2 Data reports by the Canadian Nosocomial Infection Surveillance Program show the incidence of MRSA in Canada has doubled from 1999 to 2006; VRE tripled in the same timeframe. Hospital acquired infections can extend a patient's hospital stay, lead to increased costs for treatment or complications, and in the most serious cases, can cause or contribute to the death of a patient.

4.3 Good hand hygiene, or hand cleaning, is the most effective way to help prevent or reduce the spread of hospital acquired infections. Hand cleaning is important before and after any contact with a patient, or any procedure involving contact with a patient. Other basic infection prevention and control practices include the use of appropriate protective equipment, proper cleaning and disinfecting of hospital rooms and equipment, screening new patients for risk categories, using isolation rooms when necessary, and maintaining adequate surveillance within hospitals to identify infected patients before a major outbreak can occur.

4.4 An outbreak is typically defined as having more instances of a disease than would normally occur. Most infectious diseases can lead to an outbreak. The degree of severity depends on the number of people impacted and the level of impact. Smaller or less significant hospital acquired infection outbreaks may be confined to one or two patient units in a hospital or may only cause minor issues for patients. More significant outbreaks affect more units, may involve multiple hospital sites, or can lead to serious consequences for patients, regardless of the number of people affected.

4.5 In April 2009, Nova Scotia created a new provincial organization – Infection Prevention and Control Nova Scotia (IPCNS). IPCNS is intended to provide support to district health authorities while also developing best practices to help infection control practitioners and health care workers across the province.

Audit Objectives and Scope

4.6 In 2011, our Office conducted a performance audit of the infection prevention and control practices at Cape Breton District Health Authority (Cape Breton) and Capital Health. We also audited the Department of Health and Wellness' oversight of infection prevention and control in districts. We wanted to determine whether Cape Breton District Health Authority and Capital Health had adequate policies and procedures for the prevention and control of hospital acquired infections, and whether those policies and procedures were applied. We also wanted to assess the Department's monitoring and evaluation of the impact of hospital acquired infections in Nova Scotia hospitals.

4.7 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

4.8 The audit objectives were to assess whether:

- the Department of Health and Wellness' oversight of infection prevention and control in Nova Scotia hospitals is adequate;
- Cape Breton and Capital Health are adequately monitoring hospital acquired infections and their impact on patients and the health system;
- Cape Breton and Capital Health are assessing and managing the risk of hospital acquired infections in their districts;
- Cape Breton and Capital Health have adequate infection prevention and control policies and processes;
- equipment cleaning policies and procedures are adequate and are followed;
- hand hygiene policies and processes are adequate and complied with;
- Cape Breton and Capital Health have adequate policies and processes in place to identify and respond to a hospital acquired infection outbreak; and
- Cape Breton and Capital Health complied with their respective outbreak management policies in responding to any recent outbreaks.

4.9 Certain of the audit criteria for this audit were derived from Accreditation Canada's Qmentum standards, while others were developed by our Office for this audit. The objectives and criteria were discussed with, and accepted as appropriate by, senior management at Cape Breton District Health Authority, Capital Health and the Department of Health and Wellness.

4.10 Our audit approach included examination of policies, documents and reports, interviews with various staff and management, and testing of compliance with policies and processes. Our audit period covered April 2009 to June 2011, although

some additional testing was completed following that period in certain areas. This is identified in the Chapter where applicable.

4.11 Our audit did not include the second *C. difficile* outbreak in Cape Breton in late 2011. We discussed this outbreak with IPCNS and have included some of their comments in our report. These are identified as IPCNS findings where applicable.

4.12 For our audit testing we focused on three specific hospital acquired infections: MRSA, *C. difficile*, and ventilator associated pneumonia. MRSA and *C. difficile* are both bacteria found in hospitals which can be spread and cause significant challenges for patients and the health care system. Ventilator associated pneumonia is a risk for patients who are on ventilators.

Significant Audit Observations

Department Oversight

Conclusions and summary of observations

Three years after establishing Infection Prevention and Control Nova Scotia, the Department of Health and Wellness is not adequately monitoring infection prevention and control practices in Nova Scotia hospitals. IPCNS is not sufficiently staffed to allow implementation of its objectives for infection prevention and control in the province. IPCNS has produced two guidelines but there is no requirement for district health authorities to follow these. Additionally, IPCNS does not know whether district infection prevention and control policies and processes are in accordance with best practices. There is no provincial surveillance system for hospital acquired infections. IPCNS does not collect any data from the district health authorities on the number of hospital acquired infections; as a result, the Department does not know which areas of Nova Scotia have higher rates of infection. Without monitoring it is impossible to hold the districts accountable and to ensure consistent infection prevention and control practices across the province. This can lead to districts or hospitals in which practices are inadequate resulting in a higher risk to patients of acquiring an infection in a health care facility.

4.13 Infection Prevention and Control Nova Scotia was created in 2009 and was intended to provide expertise for infection control practitioners in Nova Scotia. IPCNS' objectives include the following.

- *"Providing support for the infection prevention and control needs of the other sectors of the system that provide health related services to help facilitate a more integrated system;*
- *Developing best practice documents to help health care workers and practitioners in any setting to manage infection prevention and control issues;*

- *Providing infection prevention and control educational resources to health care facilities, community services, allied health care professionals, etc., and integrating core infection prevention and control competencies in the basic education and training programs for all health care disciplines; and*

- *Developing a provincial surveillance system with common data sets and collection methods necessary to help build capacity for comparison and monitoring of the system."*

4.14 Three years after its inception, IPCNS is failing to meet many aspects of these objectives. The Department of Health and Wellness' oversight of infection prevention and control programs in district health authorities across Nova Scotia is inadequate.

4.15 IPCNS management have developed two best practice guidelines for the districts but they do not know whether the districts use these guidelines. They told us they believe they cannot require the districts to follow IPCNS guidelines, or any other best practices; they also told us they do not know which policies the districts use. Failure to ensure consistent practices across the province means some hospitals may expose patients to a significantly higher risk of infection than others.

4.16 Section 60 of the Health Authorities Act states that the Minister shall: *"(b) develop or ensure the development of standards for the delivery of health services; (c) monitor, measure and evaluate the quality, accessibility and comprehensiveness of health services."* It is clear that ensuring province-wide infection prevention and control standards are established and implemented is well within the Department's powers.

4.17 When IPCNS was created in 2009, one of its objectives was to develop a provincial surveillance system but there has been no progress to date. Districts are not required to submit their infection rates to IPCNS and the Department does not know the level of hospital acquired infections in Nova Scotia. The lack of provincial monitoring of infection rates means each district is left largely unaware of what may be happening elsewhere in the province. This makes it more difficult to identify an outbreak in its early stages; an outbreak could spread across multiple districts before it is identified.

4.18 The lack of provincial monitoring also prevents IPCNS from examining district infection rates to help identify problems with infection prevention and control practices.

Recommendation 4.1
The Department of Health and Wellness should initiate a province-wide surveillance system operated through Infection Prevention and Control Nova Scotia to track key infection rates in all health care facilities in Nova Scotia.

Department of Health and Wellness Response:
DHW agrees with this recommendation and the need for a provincial surveillance system. IPCNS will continue to advocate and explore options for implementing a provincial

surveillance system and real-time reporting of outbreaks to IPCNS by December 2012. This will ensure provincial oversight and support to the DHAs and the fulfillment of the Department's responsibilities under the Health Authorities Act.

4.19 Management at IPCNS told us they do not have the resources to effectively audit infection prevention and control practices across the province. At the time of our audit, there were two infection control practitioners at IPCNS. While they work collaboratively with infection control practitioners across the province, IPCNS staff told us they do not have any ability to monitor, measure or evaluate hospital acquired infections or compliance measures related to infection prevention and control practices. Considering the broad range of objectives assigned to this group, two staff is not sufficient to fulfill these objectives.

Recommendation 4.2
The Department of Health and Wellness should review the staffing level at Infection Prevention and Control Nova Scotia and provide adequate staff for this division to fulfill its objectives.

Department of Health and Wellness Response:
DHW agrees with this recommendation. Initial discussions have occurred related to staffing and IPCNS is currently defining resource needs to be complete by July 2012.

Recommendation 4.3
The Department of Health and Wellness should give Infection Prevention and Control Nova Scotia the authority and responsibility to implement monitoring and oversight processes on behalf of the Department to ensure district health authorities across the province have adequate infection prevention and control practices. These practices should be consistent with any best practice guidelines identified or prepared by Infection Prevention and Control Nova Scotia.

Department of Health and Wellness Response:
DHW agrees with this recommendation of having the authority and responsibility to implement monitoring and oversight measures. DHW is currently developing an indicator framework to monitor key performance indicators, including infection prevention and control performance measures. This will ensure provincial oversight and support to the DHAs and fulfilment of the Department's requirements under the Health Authorities Act. Its expected completion is December 2012.

IPCNS will continue to develop best practice guidelines and where appropriate, take a policy-based approach, particularly for high risk issues, ensuring a higher level of accountability and adherence to evidence-based practice. In developing an indicator framework, indicator reporting to the Department will assist in ensuring DHAs are consistently adhering to accepted best practice guidelines.

To accompany recently disseminated guidelines for antibiotic resistant organisms and occupational health management of communicable diseases in healthcare workers, two additional guidelines, namely infection prevention and control in long term care and management of Clostridium difficile, are in the final stages of development and will be released September 2012. In instances where suitable guidelines have been developed by other leading authorities or expert bodies, IPCNS may opt to adopt, support and reference these evidence-based documents. Adherence to guidelines, standards, and policies will be clearly outlined to the DHAs by September 2012.

Systemic Infection Prevention and Control Problems at Cape Breton District Health Authority

Conclusions and summary of observations

We found Cape Breton District Health Authority has a poor culture of infection prevention and control. In addition, external reports from those who reviewed the District's response to a recent 2011 *C. difficile* outbreak identified failures to adopt appropriate infection prevention and control practices throughout the district. Many of the concerns we found were identified by IPCNS as contributing to the two *C. difficile* outbreaks the District experienced in the last 15 months. IPCNS found poor practices which were corrected during the original outbreak and then relapsed may have contributed to the second outbreak. IPCNS also noted poor hand hygiene as a contributing factor during the outbreaks. Our audit found that the District's hand hygiene audits were too small and not enough audits were completed.

4.20 *Systemic issues* – During our audit we identified many concerns with infection prevention and control practices at Cape Breton District Health Authority which are indicative of the systemic problems in the District. We also discussed the 2011 *C. difficile* outbreaks with IPCNS and reviewed that entity's report on the first outbreak. In some instances, this Chapter includes IPCNS findings; these are identified separately from our findings.

4.21 *Disposal of patient waste* – IPCNS identified inappropriate disposal of patient waste as a factor in the recent *C. difficile* outbreaks. Staff emptied and cleaned patient bedpans in the patient washrooms instead of in a separate dirty utility room. Cleaning in a separate location from patient rooms is a basic infection prevention and control practice which helps to limit the spread of disease by ensuring bacteria do not get recirculated in the patient's environment. Additionally, IPCNS found that spray wands were being used to clean bedpans; these can cause splashing during the cleaning process and further contaminate the environment with bacteria. Cape Breton discontinued spray wands based on recommendations from IPCNS.

4.22 IPCNS told us that following the first *C. difficile* outbreak, Cape Breton staff returned to cleaning bedpans in patient washrooms. IPCNS found this was one of the causes of a second *C. difficile* outbreak at that District in late 2011.

4.23 *Sterile processing department education* – We found Cape Breton has no requirement for ongoing education or competency checks for staff in its sterile processing department. These individuals are responsible for ensuring equipment such as surgical instruments is appropriately sterilized between patients.

4.24 We also found that infection control practitioners are not required to obtain certification related to infection prevention and control. Conversely, at Capital Health, infection control practitioners must obtain certification within five years. Both Districts told us they require infection control practitioners to complete a basic infection prevention and control program upon hiring. This requirement is not included in job descriptions at Cape Breton, although management informed us it is a standard requirement in ads for new hires.

4.25 *Lack of full-time manager* – The manager responsible for infection control in Cape Breton at the time of our audit told us this responsibility was only part of her job. She was also responsible for ambulatory care, a large department. Infection prevention and control is an important function in any hospital. Failure to commit a full-time staff member to manage this key function shows a lack of focus on this area by District management.

4.26 *Audit observations* – During fieldwork, staff from our Office observed a patient with *C. difficile* leave her room in a wheelchair and go to a common area of the hospital. We were concerned that a person who was supposed to be in an isolation room was allowed to travel around the hospital unaccompanied. Additionally, items from an infected person's room, such as a wheelchair, could carry bacteria to other areas of the hospital, potentially infecting more patients. We informed hospital staff immediately. Rather than returning the patient to her room, staff made sure she was wearing a gown and gloves and allowed her to continue unaccompanied in the wheelchair from her room. At the time, Cape Breton infection control management told us this was an acceptable practice. Subsequent to our fieldwork, Cape Breton senior management informed us this was not acceptable and that District infection control staff are drafting a new policy to address the issue. This also illustrates the lack of a strong and well-developed infection prevention and control culture at Cape Breton District Health Authority.

4.27 We found evidence that clean equipment was sometimes stored in a dirty utility room, a space used for cleaning dirty equipment. This could contaminate clean equipment. Additionally, clean items were not always tagged or otherwise identified; staff may not know which items are clean and which are not. This could pose an increased risk to the patient of equipment being used which was not cleaned and disinfected. We also noted dirty items were sometimes stored in open containers which increases the possibility of contamination.

4.28 We identified additional indicators of a pervasive lack of attention to infection prevention and control at Cape Breton.

- There are no infection control practitioners on the Quality/Patient Safety Committee. Typically this type of committee would include practitioners to help ensure adequate infection prevention and control.
- The infectious disease doctors at Cape Breton told us they believe senior management at the organization did not fully appreciate the importance of infection prevention and control prior to the recent *C. difficile* outbreaks. They felt the situation improved more recently.
- At the end of our audit, infection control management continued to claim bleach is an effective cleaner. Bleach is a disinfectant and infection prevention and control best practice clearly states that disinfectants should be used after a surface has been cleaned with a general or hospital-grade cleaning agent.

4.29 Infection control practitioners told us they do not visit patient floors regularly, even when a new case of a hospital acquired infection is identified. They told us they phone the unit to ensure proper precautions are in place but do not visit to ensure staff understand the precautions and are applying them appropriately. Additionally, infection control practitioners rarely visit some of the small rural hospitals in the District from November to April each year due to the possibility of poor weather. Infection control practitioners need to be visible on units in hospital facilities year round. This reinforces the need for good infection prevention and control practices with staff and helps illustrate an organization's commitment to a strong infection prevention and control culture. Staff may also feel more comfortable discussing potential problems with someone they see regularly on the unit. It should be possible for infection control practitioners to plan visits to rural facilities and cancel if the weather forecast shows reason for concern.

Recommendation 4.4
Cape Breton District Health Authority should implement a process to address infection prevention and control in all hospitals throughout its District year round, including regular visits by infection prevention and control practitioners.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation. The District has increased ICP (Infection Control Practitioner) staffing by 3.0 FTE and has assigned ICPs to all facilities. One ICP will be located in Inverness part time and will also visit Cheticamp and Neil's Harbour routinely. One ICP located in North Sydney will make regular visits to Baddeck. ICPs are also assigned to all industrial Cape Breton facilities and make regular visits.

4.30 Each of the individual issues noted throughout this section is concerning; when considered together, these issues provide a clear picture of the lack of focus on infection prevention and control at Cape Breton. This failure to take infection prevention and control seriously may have contributed to the recent *C. difficile* outbreaks in Cape Breton and may have hampered efforts to limit the impact of those outbreaks.

Outbreak Management

Conclusions and summary of observations

We found significant issues with Cape Breton's response to the *C. difficile* outbreak in early 2011. Infection Prevention and Control Nova Scotia issued a report on this outbreak which identified a number of failed infection prevention and control practices. Although Cape Breton has outbreak management policies, we found these were not implemented well in practice. District management also told us their outbreak policies are not adequate and informed us the policies are being updated. Cape Breton's response to the outbreak was not timely. It took almost a week to inform the public and implement visitor restrictions in the District-wide outbreak. IPCNS was not informed of the unit outbreaks, and were called only when the District-wide outbreak was declared. We noted delays in implementing changes once problems were identified during the initial outbreak. We found that Capital Health has appropriate outbreak management policies. There were no significant outbreaks during our audit period so we did not assess the application of these policies.

4.31 *Policies* – Outbreak policies are typically somewhat generic so that they can be applied to various types of outbreaks. The policies usually provide for staff and volunteers to fulfill their normal duties. Members of the outbreak team may have more authority than usual.

4.32 We found both Districts had outbreak policies. Cape Breton management told us they believed their policy was not adequate. We noted that Cape Breton was in the process of updating its policies to reflect lessons learned from the recent *C. difficile* outbreak.

4.33 *Outbreaks* – We asked both Districts to identify any outbreaks they experienced during our audit period (April 2009 to June 2011). An outbreak can range from something minor in which a few patients become ill, to a more serious situation with severely ill patients, or many patients becoming sick. Where applicable, we reviewed the reports prepared following any hospital acquired infection outbreaks.

4.34 *Capital Health* – During our audit period, Capital Health had 10 small outbreaks. Due to the limited nature of most of the outbreaks, reports were only prepared for four of these. We reviewed these reports and determined that none of the outbreaks were significant and all related to either influenza-like illnesses or noroviruses, neither of which were the focus of our audit.

4.35 *Cape Breton* – We focused our examination of Cape Breton's outbreak response on the first multi-site *C. difficile* outbreak that occurred in early 2011. Subsequent to our audit period, Cape Breton suffered another outbreak of *C. difficile* at the Cape Breton Regional Hospital. We did not audit the response to this outbreak because it occurred after we had completed our fieldwork. However, we did discuss it with Infection Prevention and Control Nova Scotia and include their comments in this Chapter where applicable.

4.36 *Outbreak response* – Cape Breton infection control management told us there were 11 hospital acquired infection outbreaks in their District during our audit period. However, despite a District policy requirement, Cape Breton management told us they do not prepare after-outbreak reports. They told us they believe outbreak issues are covered in the minutes of their outbreak meetings.

4.37 Best practices in infection prevention and control include internal reviews of outbreak responses to identify what worked well versus what did not. While regular meetings during an outbreak are important, these do not replace the need for a thorough review of the response after the outbreak is over. A review provides an opportunity to examine the entire outbreak response from beginning to end and takes place immediately after the outbreak is finished. Failure to complete a review after an outbreak can result in the same problems occurring in the future.

4.38 IPCNS and the Public Health Agency of Canada examined Cape Breton's response to the initial *C. difficile* outbreak. We reviewed comments from both agencies during our audit work. Although these agencies examined Cape Breton's response to the outbreak, we believe it would also be beneficial for Cape Breton to prepare its own report focusing on the response to the outbreak and what could be done differently to avoid future outbreaks or to deal better with them. Such a detailed review of the outbreak could also help staff to better understand their role in infection prevention and control.

4.39 As discussed, Cape Breton did not review its response to the initial *C. difficile* outbreak. IPCNS told us that Cape Breton staff later resumed many of the problematic routines which may have contributed to this outbreak and in late 2011, the District experienced another *C. difficile* outbreak. District management told us they believe staff returned to their former approach because they do not accept their own responsibility for infection prevention and control. Further, management told us they do not believe outbreak reporting will impact the lack of understanding of infection prevention and control in the District. Cape Breton did prepare an after-outbreak report for the second outbreak. This was released while we were writing this Chapter. We have not included this report in our audit.

Recommendation 4.5
Cape Breton District Health Authority should prepare a formal report for both C. difficile outbreaks in the District in 2011. The report should consider the problems which contributed to the outbreak and challenges experienced during the response.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation. A formal outbreak report was issued on March 14, 2012 for the second outbreak. An outbreak report will be prepared for the first outbreak before May 30, 2012 with the benefit of references to the Public Health Agency of Canada Report, the IPCNS Lessons Learned report and the CEO report to the Community pertaining to this outbreak.

Recommendation 4.6
Cape Breton District Health Authority should prepare after-outbreak reports for any significant outbreaks in the District. The reports should address the cause of the outbreak, any issues or concerns with the response and provide recommendations for improvement where applicable.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation. Outbreak reports are now prepared that address the probable cause of any outbreak, discuss issues and concerns with response and identify opportunities for improvement.

4.40 We found there is no requirement for district health authorities to report hospital acquired infection outbreaks to IPCNS. In this instance, Cape Breton management did not inform IPCNS that they were experiencing unit outbreaks in their hospitals. These outbreaks ultimately led to the District-wide outbreak. Cape Breton management did contact IPCNS when they determined the outbreak was District-wide. This was almost a month after the first unit outbreak. IPCNS staff have expertise in infection prevention and control; they should be involved in responding to any significant outbreaks in the province. As well, IPCNS should be informed of all outbreaks so the Department of Health and Wellness can monitor the situation.

Recommendation 4.7
The Department of Health and Wellness should require district health authorities and other health care organizations to report all outbreaks and health care or hospital acquired infections to Infection Prevention and Control Nova Scotia immediately.

Department of Health and Wellness Response:
DHW agrees with this recommendation. IPCNS will determine the most appropriate methods for reporting by the district health authorities and other healthcare organizations, parameters and criteria for what and when to report, and how IPCNS will utilize and respond to the information. The expected timeline is September 2012.

4.41 *Second outbreak* – In late 2011, Cape Breton experienced a second *C. difficile* outbreak. We did not audit this outbreak because it took place after we completed our fieldwork. However, we did discuss it with IPCNS at the conclusion of our audit. They told us that Cape Breton hospital staff returned to some of the routines which IPCNS had identified as problems in the first outbreak. IPCNS noted these issues were at least partially responsible for the second *C. difficile* outbreak in Cape Breton.

4.42 For example, IPCNS told us that Cape Breton staff returned to handling patient waste inappropriately by cleaning bedpans in patient washrooms. This was identified as a problem in the first outbreak. If appropriate infection prevention and control practices are followed, patient waste and bedpans should be moved to a dirty utility room for cleaning.

4.43 Returning to old practices which may have contributed to the initial outbreak demonstrates the lack of infection prevention and control culture at Cape Breton District Health Authority. This is not acceptable in a health care organization and is particularly concerning following a significant outbreak.

4.44 Failure of District staff to maintain updated practices also magnifies the need for a report to examine the issues around each significant outbreak. This would provide an opportunity for management and staff to assess any issues which may have contributed to the outbreak, as well as look at what could have been done differently during the response. A written report documenting the issues and identifying changes needed may help staff to understand the importance of appropriate infection prevention and control and staff's role in ensuring good practices.

4.45 *IPCNS reporting* – We reviewed two after-outbreak reports, one prepared by IPCNS, the other by the Public Health Agency of Canada. These reports identified many areas in which Cape Breton's infection prevention and control practices were not appropriate. IPCNS also provided verbal comments and draft reports to Cape Breton prior to finalizing their outbreak report.

4.46 The IPCNS report demonstrates the systemic failure to put in place appropriate infection prevention and control practices in Cape Breton. This report identified 37 recommendations for improvement; these are detailed in Appendix 1 at the end of this Chapter. The following are some examples of the improvements IPCNS recommended.

- Require infection control staff to obtain certification within two to five years of hiring.
- Require continuing education and recertification for infection control practitioners.
- Increase the presence of infection control practitioners in hospital units by completing daily rounds.
- Increase and improve surveillance practices.
- Infection control practitioners should perform ongoing audits of various aspects of infection control.
- Ensure infection control practitioners are involved in product procurement and evaluation.
- Repair or replace non-intact furnishings and surfaces.
- Adopt best practices for proper cleaning of commodes and bedpans.
- Ensure removal of all spray wands in patient bathrooms and dirty utility rooms.
- Increase the number of hand washing units.

- Increase the number of audits and observation of compliance with hand hygiene policies.
- Engage infection control practitioners in selection and purchase of cleaning and disinfectant products.
- Ensure proper cleaning of patient rooms, including preparation of detailed checklists for environmental services and regular audits by infection control practitioners.
- Implement immediate contact precautions for unexplained diarrhea; minimize the number of transfers of symptomatic patients.

Recommendation 4.8
Cape Breton District Health Authority should implement all recommendations identified by Infection Prevention and Control Nova Scotia in its report on the C. difficile outbreak.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and plans to have fully implemented all 37 recommendations by September 2012. Monthly progress reports are currently prepared and submitted to document progress. These reports will be posted on the CBDHA web site.

4.47 *Poor practices* – IPCNS also identified a number of areas in which appropriate infection prevention and control practices were not followed. During our audit, we discussed these issues which IPCNS had identified with Cape Breton management.

- Improper waste management.
- Bedpans and commodes were cleaned in patient rooms.
- Spray wands were used to clean bedpans and commodes in both patient rooms and dirty utility rooms (a space for cleaning dirty equipment).
- Inappropriate cleaning products were used to clean patient rooms. Cape Breton was using bleach alone to clean rooms but bleach is a disinfectant, not a cleaning product. Surfaces need to be cleaned with an appropriate product before applying disinfectant. In addition, staff did not ensure surfaces remained wet for the minimum contact time with bleach to ensure proper disinfection. As a result, the surfaces were neither properly cleaned nor properly disinfected.

4.48 These are basic infection prevention and control practices that should be properly addressed under any circumstance in a hospital setting. Failure to properly monitor, or to understand the importance of these practices, is indicative of the systemic infection prevention and control issues in Cape Breton.

4.49 *Furnishings and equipment* – IPCNS outbreak report noted areas in which furniture and equipment in Cape Breton was deemed unacceptable, usually because it was not possible to fully clean. We also identified some of these same issues during our audit. Examples of unacceptable furniture and equipment include:

- commodes with uneven surfaces;
- backsplash or facing materials in washrooms;
- bedside tables with chips in the finish exposing rough wood surfaces; and
- furniture with rough or porous surfaces.

4.50 *Timing of Cape Breton's outbreak response* – We identified a number of situations in which Cape Breton was slow to respond or to seek assistance in the early stages of the outbreak.

- Service providers were not notified until four days after the district outbreak was declared.
- The public was notified and visitor restrictions put in place five days after the outbreak began.
- After IPCNS told Cape Breton that using spray wands to clean was inappropriate, it took five days for all spray wands to be removed from all patient bathrooms.
- It took 12 days to replace inappropriate cleaning products identified by IPCNS. While cleaning staff were told to change existing practices in late March, this directive came from materials management rather than someone involved with infection prevention and control. Additionally, no information was provided to cleaning staff to explain that existing practices did not kill *C. difficile*.
- Emergency call cords in patient bathrooms were identified as not able to be cleaned, but it took Cape Breton 25 days to replace them. Cape Breton ordered the replacement products 12 days after they were identified as a problem but experienced delays in receiving replacements.

4.51 *Infection control compliance audits* – In its report on Cape Breton's outbreak response, IPCNS identified the need for more compliance auditing and the general lack of visibility of infection prevention and control staff throughout hospitals in Cape Breton. We identified similar issues during our audit. Audits of hand hygiene, equipment reprocessing or other areas, help to address both of these issues. Without assessing compliance, infection control practitioners have no way to know whether staff are following policies. Completing audits also requires infection control practitioners to visit hospital units and interact with staff, service providers and volunteers. This provides opportunities for education and can help improve the understanding of infection prevention and control in the District.

4.52 *Capital Health* – During the course of our audit, infection prevention and control management at Capital Health told us that they also had spray wands in many of their facilities. In light of the findings from Cape Breton, Capital Health management told us they decommissioned spray wands to ensure they were no longer used, with the exception of the Dartmouth General. This hospital has no rooms on each unit in which dirty equipment can be cleaned so there is no alternative but to continue to use the spray wands. Management told us that building renovations would be required to remedy this situation.

Recommendation 4.9
Capital Health should approve and implement necessary changes to discontinue the use of spray wands in all its facilities.

Capital Health Response:
Capital Health accepts this recommendation. Where possible, all spray wands have already been decommissioned in the District. Renovations to Dartmouth General are required to ensure compliance with a human waste disposal program and were requested through a submission to the Department of Health and Wellness for funding as a repair/renewal project. Renovations to construct dirty utility rooms with an automated system for disposing human waste and cleaning bedpans would result in a decrease in the number of patient care beds, with a resulting negative impact on patient flow. Proposed construction of the 5th floor of the Dartmouth General presents an opportunity to relocate patient care rooms and provide space to incorporate the required human waste disposal systems

Policies and Practices

Conclusions and summary of observations

We found that both Capital Health and Cape Breton have infection prevention and control policies, although in both Districts, many policies were outdated. Both Districts told us their infection prevention and control policies are developed from evidence-based best practices, but neither district consistently references the source of their policies. We found Capital Health includes its infection control practitioners in key areas across District operations. In contrast, Cape Breton does not include its infection control practitioners in many important decisions, including equipment and furniture purchases and new construction planning.

4.53 *Policies* – Both Capital Health and Cape Breton have extensive infection prevention and control policies and both Districts told us that they use evidence-based or best practice policies where possible. However, we found neither District consistently notes the source of its policies making it difficult to assess whether policies are in fact evidence-based. We found eight policies at Capital Health and five policies at Cape Breton with no sources identified.

Recommendation 4.10
Capital Health and Cape Breton District Health Authority should reference all infection prevention and control policies to the evidence-based best practices on which they were developed.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has commenced immediate referencing to evidence based practice for all new policies and procedures and will revise all existing policies and procedures to include reference to evidence based best practices.

Capital Health Response:
Capital Health agrees with this recommendation. Capital Health considers information from all recognized sources of (e.g. Public Health Agency of Canada, Centers for Disease Control and Prevention, Canadian Standards Association, Legislation, Accreditation Standards, the Ontario Provincial Infectious Disease Advisory Committee (PIDAC)), and expert opinion (particularly if no authoritative sources are identifiable) when developing policies. The available literature is reviewed and interpreted and the policy developed. Capital Health will ensure that these references are cited on all future policies.

4.54 Both Districts require policies be reviewed every three years to determine if updates are required. Despite this, we identified eight policies in Capital Health and 14 in Cape Breton which had not been reviewed in more than three years.

Recommendation 4.11
Capital Health and Cape Breton District Health Authority should implement a process to review all infection prevention and control policies on a regular basis. Policies should be updated based on any changes identified from these reviews.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed a schedule for routine review and revision of all IPAC policies and procedures and has assigned responsibility to ensure that this activity occurs regularly. 17 of 18 policies over 3 years old have been updated as of April 25, 2012.

Capital Health Response:
Capital District agrees with this recommendation. Capital Health uses a broad stakeholder engagement process to develop and review policies. Capital Health's new document management system (Medworxx Policy Document Management System) provides automatic notification to the responsible departmental contact on a regular basis until the new/updated policy is submitted to the Policy Office. As well, an audit process, with feedback to leadership on all outdated policies, is being implemented.

4.55 *District-wide involvement* – Infection control practitioners should be involved in a wide variety of decisions in a hospital setting. Everything from the cleaning

solutions used to the type of furniture purchased for patient rooms or lounges can have a significant impact on the ability to prevent or control the spread of hospital acquired infections.

4.56 We found that Capital Health's infection control practitioners were involved in all the areas we expected including product evaluation for equipment and furniture purchases, policy development for food delivery and housekeeping, and construction project planning.

4.57 We found infection control practitioners in Cape Breton were not adequately involved in decision making throughout the District. Although infection control practitioners are supposed to be involved in the product evaluation committee, this group did not meet between April 2009 and August 2011. Practitioners were involved in policy development around food delivery and housekeeping but were not active participants in construction planning.

4.58 Failure to involve infection prevention and control expertise can lead to many issues including furniture and equipment which is difficult or impossible to properly clean, inappropriate construction materials used in washrooms and other areas, and inappropriate equipment from an infection prevention and control standpoint.

Recommendation 4.12
Cape Breton District Health Authority should implement processes to ensure that infection prevention and control staff are involved in all decisions with the potential to impact infection prevention and control in the District. Among other areas, this would include construction projects and all equipment and furniture purchases.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has established process to ensure that IPAC staff participates in Materiel Management, Engineering Services, Environmental Services and Quality and Patient Safety decisions to ensure that infection prevention and control implications are recognized and addressed.

4.59 We noted both Districts have fairly extensive education programs and literature available to help staff, service providers, volunteers, patients, and patients' families understand their respective roles in infection prevention and control.

Medical Equipment Cleaning and Disinfecting

Conclusions and summary of observations

We found significant problems in Capital Health's processes to ensure internal scopes are appropriately disinfected. We identified one scope for which there was no evidence that the scope was disinfected before being used on another patient. We also identified issues with Cape Breton's processes to ensure these scopes are properly cleaned and disinfected.

We found two scopes for which there was no evidence the scopes were cleaned and disinfected prior to being used again. Overall, sterile processing in both Districts was adequate, although we identified a few situations in which the process was not consistent with the manufacturer's requirements. We found many instances at both Districts in which flash sterilization was used to sterilize equipment in nonemergency situations. This is considered inappropriate based on Canadian guidelines; this form of quick sterilization is only to be used in emergencies.

4.60 *Internal scope cleaning and disinfecting* – Internal scopes are used for a variety of procedures at both Districts. We examined the processes for cleaning and disinfecting gastrointestinal scopes, bronchoscopes and colonoscopes. We wanted to assess whether each District had an adequate process to ensure scopes are cleaned and disinfected before being used again; we also wanted to verify there was adequate evidence of this.

4.61 Generally both Districts use a similar process to clean and disinfect scopes. This starts with a pre-cleaning immediately after use, followed by a more thorough manual cleaning, and finally a cycle in a high-level disinfectant machine prior to being returned for use on another patient.

4.62 *Sterile processing* – Hospitals clean equipment for surgeries and other procedures in sterile processing departments. These departments have procedures, including manual cleaning, washing/disinfecting machines, and sterilization machines, to ensure items are properly sterilized before being returned for use. While facilities may have different machines, these are all designed to sterilize equipment before use.

4.63 *Sample selection* – We selected a sample of 20 days at each hospital we visited and tested scope cleaning and disinfecting records and sterile processing records. The number of scopes versus sterile processing items included in our sample depended on the volume of scope procedures at each facility.

4.64 *Capital Health scope testing* – We tested scope cleaning and disinfecting practices at the Victoria General, Halifax Infirmary, Dartmouth General and Hants Community Hospital. We found Capital Health did not have adequate processes to ensure its scopes were adequately disinfected before being returned to use. Capital Health's logs showed manual cleaning was completed for all the scopes we tested. However, we found staff were not reviewing printed tapes from the disinfectant machines to ensure high-level disinfecting cycles were completed. For many of the scopes we tested, the printed tapes showed cycles were aborted or the tape stopped mid-cycle. When we discussed this issue with Capital Health staff, they were able to download detailed data from these machines and were eventually able to demonstrate that most scopes in our sample were properly disinfected. However, there was one scope for which there was no evidence it was properly disinfected before being returned for use on the next patient. Following our testing, Capital Health staff told us that they contacted this patient to inform them of what happened.

4.65 The process we followed to get this evidence was extremely time consuming and tedious. Although we were able to verify that all scopes tested except for one were properly disinfected, we are concerned that the printed tapes had no evidence to prove this. Staff could not have been certain scopes were properly disinfected before being returned to use. If Capital Health had to trace the history of a scope in an emergency situation, they might be delayed by the lack of evidence. If staff were required to verify each completed disinfecting cycle, this would reduce the risk an aborted or incomplete cycle could go undetected.

4.66 *Cape Breton scope testing* – We tested scope cleaning and disinfecting practices at Cape Breton Regional Hospital and Glace Bay Hospital. While the process staff at Cape Breton Regional Hospital described to document scope cleaning and disinfecting was appropriate, we found it was not applied consistently.

4.67 At Glace Bay Hospital, staff used a variety of processes to document scope cleaning and disinfecting during our audit period. Sometimes patient logs were maintained and at other times, logs were not kept. Much of the documentation supporting cleaning and disinfecting cycles was not stored by date and it was difficult to locate records. Again, this could be an issue if a scope had to be traced to patients or cleaning and disinfecting cycles in an urgent situation.

4.68 Our testing identified two scopes at Cape Breton District Health Authority for which there was no evidence the scopes were properly cleaned and disinfected before being returned to use. We downloaded data from the disinfectant machines where possible but there was nothing to indicate these two scopes were appropriately cleaned and disinfected.

Recommendation 4.13
Capital Health and Cape Breton District Health Authority should implement a consistent process for all hospitals in the District that ensures:

- ***all scopes are properly cleaned and disinfected;***
- ***staff verify the cleaning processes were completed; and***
- ***clear and well-documented evidence of the cleaning process.***

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed and implemented new policies and procedures that will consistently ensure that there is evidence that all scopes have been properly cleaned.

Capital Health Response:
Capital Health accepts this recommendation, most specifically the recommendation which identifies the need to implement a process for documenting subsequent reprocessing steps (see further detail below). Capital Health has a written process for endoscope and bronchoscope reprocessing. The process follows the Public Health Agency of

Canada's guidance document "Infection Prevention and Control Guideline for Flexible Gastrointestinal Endoscopy and Flexible Bronchoscopy". We have had, for a number of years, 1) written policies and procedures and written protocols for cleaning and reprocessing each type of endoscope that are based on current recognized standards and recommendations as well as manufacturer recommended protocols and 2) formal, documented endoscope reprocessing staff training and annual recertification.

As the Auditor General's Report indicates, we have good documentation of our cleaning process. We agree that we need to implement a process for documenting subsequent reprocessing steps. An Endoscopy Reprocessing Quality Improvement group was established in November 2011. A formal audit process for evaluating endoscope reprocessing was implemented in January 2012. This includes self-audit of documentation practices by the unit's leadership and reconciliation of the reprocessing documentation practices on a daily basis. In March 2012, Infection Control commenced monthly audits of the reprocessing processes, with direct observation of the reprocessing procedure from cleaning to storage.

4.69 *Sterile processing department* – All the hospitals we visited had dedicated sterile processing departments for cleaning and sterilizing most medical equipment used in the facility other than scopes. This includes surgical equipment, such as scissors, clamps and drills, as well as any other equipment requiring sterilization.

4.70 *Records and testing* – We found all the facilities we audited maintained appropriate records of equipment sterilization. We selected a sample of equipment and verified that the cleaning process matched the manufacturer's requirements. Our overall equipment cleaning testing was divided between scopes and sterile processing; accordingly the sample sizes of sterile processing testing vary between facilities depending on the volume of scopes used at a facility.

4.71 *Capital Health sterile processing testing* – We tested 50 items to ensure they were appropriately sterilized. We found no issues in the length of sterilization, the temperature ranges achieved or the daily monitoring of the sterilization equipment. We identified two items for which the drying time in the sterilization cycle did not meet the manufacturer's requirements.

4.72 *Cape Breton sterile processing testing* – We tested 20 items at Cape Breton; we had no concerns with the length of sterilization, temperatures, or daily monitoring of sterilization equipment. We did identify two items for which the drying cycle was not consistent with the manufacturer's requirements.

Recommendation 4.14
Capital Health and Cape Breton District Health Authority should implement processes to ensure that all aspects of sterilization are consistent with manufacturer's requirements.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has established processes that ensure that all existing and new equipment requiring sterilization has both policy and standard operating procedure developed to ensure that all aspects of sterilization are consistent with the manufacturer's requirements.

Capital Health Response:
Capital Health agrees with this recommendation. The drying time in the sterilization cycles for the two identified items was changed, in accordance with the manufacturer's recommendation. Capital Health follows the Canadian Standards Association's Recommended Standards of Practices for Sterilization. This includes a process for obtaining validated manufacturer's reprocessing instructions for all new medical devices.

A multi-disciplinary Reprocessing Committee is in the process of being formed to standardize processes to ensure equipment is reprocessed using CSA Standards and best practice guidelines. Prior to purchase of the equipment/device, all parties involved must be in agreement that the procedure for reprocessing the equipment/device satisfies the required reprocessing criteria and is achievable in the health care setting.

4.73 *Flash sterilization* – Flash sterilization is a means of sterilizing a piece of equipment at or near the point of use (such as an operating room), rather than returning the equipment to the sterile processing department. Canadian Standards Association (CSA) guidelines and Health Canada guidelines both indicate flash sterilization should only be used in emergency situations in which an instrument has fallen on the floor, or otherwise become unsterile, and is needed immediately for a surgery. These guidelines also require that hospitals keep records of flash sterilization. Scheduling too many surgeries for the equipment available or the lack of necessary instruments should never be used as a reason to flash sterilize an instrument or set of instruments.

4.74 Both Districts have policies governing the use of flash sterilization which are consistent with Health Canada and CSA guidelines. However, neither District is in compliance with its policies. Additionally, Capital Health's policy is still draft, and Cape Breton's policy was approved during our audit.

4.75 Capital Health had records of items sterilized using flash technology. Cape Breton only started maintaining these records at the start of our audit. Cape Breton staff informed us that the flash log was started in response to our audit.

4.76 *Capital Health testing* – We reviewed Capital Health's flash sterilization records and identified 20 types of equipment which were most often flashed at the Capital facilities we visited. We asked management why these items were flashed. For 18 of the 20 equipment types, we determined the hospitals used flash sterilization either because too many surgeries were scheduled or the hospital did not have a sufficient inventory of that equipment. Neither of these reasons is considered acceptable under Canadian guidelines.

4.77 Since flash sterilization is only to be used in emergencies, we asked District management what they were doing to address this situation.

- In 11 instances, Capital Health had already acquired additional inventory of instruments. Management told us this should be sufficient so that flash sterilization will not be required due to lack of equipment.
- One item is still pending approval for additional inventory purchase.
- In one situation, management told us they are monitoring surgery scheduling to ensure flash sterilization is no longer needed.
- The remaining five equipment types have not been flash sterilized in over a year and management told us they believe no further action is needed.

4.78 *Cape Breton testing* – Since Cape Breton only began maintaining records of its flash sterilization at the start of our audit, we extended our audit period to early February 2012 in this area. We found that Cape Breton was using flash sterilization in nonemergency situations. We tested 10 items logged as flash sterilized since Cape Breton began keeping records and found six were flashed for inappropriate reasons. In all six cases, management told us they are working to acquire or have already acquired additional pieces of equipment to ensure flash sterilization is not required in the future.

Recommendation 4.15
Capital Health should finalize its flash sterilization policy.

Capital Health Response:
Capital Health agrees with this recommendation.

Recommendation 4.16
Capital Health and Cape Breton District Health Authority should implement processes to ensure flash sterilization is only used in situations which are acceptable based on national best practices.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation. Policy and procedure for flash sterilization that references best practices was developed and implemented in November 2011. Routine audits of flash sterilization records are conducted to evaluate compliance and detect opportunities for improvement.

Capital Health Response:
Capital Health accepts this recommendation. Capital Health uses the Canadian Standards Association's Recommended Standards of Practices for Emergency (Flash) Sterilization. Capital Health has taken actions to decrease the use of flash sterilization: purchasing more equipment, transferring equipment among hospitals, increasing availability of

single wrapped equipment. Peri-operative portfolio leadership reviews flash records for equipment purchase recommendations and adjusts OR booking to prevent overbooking of instrumentation.

4.79 *Sterile processing department audits* – Capital Health infection control staff conduct regular audits of the sterile processing department to ensure workflow and processes are compliant with policy. Cape Breton has not completed any audits of sterile processing, instead relying on staff to conduct self-audits and identify issues. As discussed earlier, audits by infection control practitioners are an important mechanism to ensure infection prevention and control policies are followed.

4.80 The lack of regular sterile processing audits by Cape Breton infection control practitioners is another indicator of that District's poor infection control culture.

Recommendation 4.17
Cape Breton District Health Authority should immediately implement a process to ensure that infection control staff conduct regular audits of all sterile processing units in the District.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has assigned a dedicated Infection Prevention and Control Nurse to complete regular audits for all sterile processing units in the District. Auditing by an ICP commenced in January 2012.

4.81 *Sterile processing staff qualifications* – Both Districts have specific qualifications which staff working in the sterile processing departments must meet. We tested staff qualifications at Capital Health and Cape Breton and found the following.

- All 31 staff reviewed at Capital Health met the District's requirements to work in sterile processing.
- Nine of the 11 staff reviewed at Cape Breton met that District's requirements. The remaining two staff members obtained the necessary qualifications two and six months later than required.

4.82 We noted that Capital Health's job description for sterile processing staff included an education requirement which District staff told us is not necessary.

Recommendation 4.18
Capital Health should review sterile processing position descriptions to verify education requirements are accurate.

Capital Health Response:
Capital Health agrees with this recommendation. Steps are already under way to ensure that any discrepancies in relation to documentation of such requirements are rectified.

4.83 *Staff competency and continuing education* – In the fall of 2010, Capital Health implemented annual competency checks for all sterile processing staff. At the time of our audit, a competency check had been completed for 15 of the 31 staff. Capital Health also requires staff complete an annual continuing education program; the District monitors compliance. We reviewed the process in place to monitor continuing education for sterile processing staff and found it was adequate.

Recommendation 4.19
Capital Health should update its processes for annual competency checks of sterile processing staff to ensure these checks are completed as required by District policy.

Capital Health Response:
Capital Health agrees with this recommendation and will continue with its current process of annual competency review of sterile processing staff. Competency assessments were completed by all SPD staff (with the exception of those on leave) by the end of 2011.

4.84 Cape Breton does not complete competency checks of sterile processing staff; the District has no continuing education requirements for those staff. Competency checks and ongoing education are important to ensure staff are aware of the most recent developments in their area.

Recommendation 4.20
Cape Breton District Health Authority should implement regular competency checks of sterile processing staff.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has established both a process and schedule for regular yearly competency checks of all staff by the Supervisor utilizing a validated checklist in addition to a random and routine auditing process. The first round of competency checks will be completed by September 2012.

Recommendation 4.21
Cape Breton District Health Authority should implement continuing education requirements for sterile processing staff.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and to this end has developed and commenced a continuing education program for staff with monthly required education sessions ranging from 30 minutes to 4 hours duration. Education sessions target all core competencies and those functions requiring regular recertification.

4.85 *Reprocessing single-use devices* – Certain health care devices have been declared as suitable for single-use only by manufacturers. This means these items are disposable, intended to be used once and discarded. However this practice can prove very costly

and some areas of health care have explored implementing third party reprocessing (cleaning and disinfecting) of certain of these devices.

4.86 *Capital Health* – In 2011, Capital Health began sending certain single-use devices for reprocessing in order to help mitigate budget pressures. The District has a detailed policy which includes the requirement that reprocessing will only occur at a facility approved by either Health Canada or the Food and Drug Administration (USA). Capital Health has a list of items they have approved for reprocessing and have an agreement with an FDA-approved facility to carry out reprocessing.

4.87 *Cape Breton* – Cape Breton had not determined whether to proceed with reprocessing of single-use devices at the time of our audit. Various groups at that District have considered this issue and concerns were noted over both the process and the limited potential cost savings to Cape Breton. District senior management told us they are actively reviewing the options available at the current time.

4.88 There is no clear analysis of the potential cost savings associated with reprocessing single-use devices, but given the costs involved – up to $3,900 for certain items in the cardiac catheterization lab at Capital Health – the impact on the provincial health budget is significant enough that the Department of Health and Wellness should consider the issues.

Recommendation 4.22
The Department of Health and Wellness should review single-use device reprocessing and develop a provincial policy which all district health authorities can follow.

Department of Health and Wellness Response:
DHW agrees with the recommendation to review and develop a provincial policy for all DHAs to follow. IPCNS has been providing evidence-based support to districts investigating reprocessing of single-use devices; however IPCNS will develop a consistent, policy-based approach to ensure current standards and best practices are implemented in the DHAs by December 2012.

Hand Hygiene

Conclusions and summary of observations

Capital Health has adequate policies regarding hand hygiene and District infection control practitioners have done a good job of auditing to assess existing practices and improve performance. Although Cape Breton has similar policies to Capital Health, at the time of our audit, Cape Breton had only completed a small number of hand hygiene audits, each of which was quite small relative to the Capital Health audits. We found that Cape Breton did not adequately monitor to ensure appropriate hand hygiene practices in its facilities.

4.89 *Hand hygiene policies* – Both Districts have hand hygiene policies based on national programs, although the signage and materials used by Cape Breton are based on an older version of these programs.

4.90 *Monitoring compliance* – Staff at both Districts told us that auditing hand hygiene is the primary means by which infection control staff can monitor compliance, and that the communication of those results and subsequent education sessions are the primary approach to improving hand hygiene practices in their Districts.

4.91 Basic hand hygiene audits involve infection control practitioners spending time on a health care unit monitoring staff and service providers as they interact with patients. There are four moments identified during patient interaction in which the health care professional should either clean their hands with soap and water or use an alcohol-based rub. The four moments for hand hygiene are before contact with the patient environment, before an aseptic procedure, after exposure to body fluids, and upon leaving the patient's environment. The premise of the audits is to record each moment and note whether the staff member properly cleans his or her hands.

4.92 Audits are typically conducted in two phases. The first is a baseline audit to determine the level of hand hygiene prior to taking any specific action. These baseline audits are followed by education programs, particularly for areas with lower results. Subsequent audits are completed to assess the success of the education programs.

4.93 *Capital Health* – At Capital Health, the infection control practitioner visits a hospital unit and records information whenever health workers or support staff enter rooms. In some instances, the practitioner may not be able to observe what happens when a health care worker enters a patient room, depending on the nature of the procedure and concerns with patient privacy. This is a common issue with hand hygiene audits but is a reasonable compromise given the nature of these situations.

4.94 All infection control practitioners at Capital Health conduct hand hygiene audits on the units they are responsible for. During our audit, we completed walkthroughs of Capital's hand hygiene audits and found there is a high level of awareness of infection control practitioners on those units.

4.95 Capital Health completed hand hygiene audits on all of its inpatient units as well as other areas such as emergency. During our audit period, Capital conducted 52 audits at the four facilities we visited. This represents 31 initial audits and 21 follow-up audits. Capital Health's audits have averaged approximately 184 moments for health care workers including physicians, nurses and others.

4.96 *Cape Breton* – Cape Breton's methodology for hand hygiene audits is different from Capital Health, but consistent with national guidelines. The infection control practitioner conducting the audit follows a single health care worker as this person completes work on a unit. Similar to Capital Health, the infection control practitioner

does not follow the worker into a patient's room. All of Cape Breton's hand hygiene audits are completed by one infection control practitioner who works on a part-time basis having retired in 2009.

4.97 Although both Districts follow national practice guidelines, we believe the process Capital Health uses is more effective. It involves more staff completing the audits and provides for better coverage by observing many staff members' hand hygiene habits.

Recommendation 4.23
Cape Breton District Health Authority should have all infection control practitioners conduct hand hygiene audits on the units and facilities for which they are responsible.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed an improved auditing process for hand hygiene as a component of the new comprehensive Hand Hygiene program. All ICPs will conduct hand hygiene audits in their areas of assigned responsibility as well as a variety of other trained health care workers who will assist in providing accurate audit results.

4.98 At the time we completed our fieldwork, Cape Breton had only conducted 14 hand hygiene audits – eight initial audits, including one long term care unit, and six follow-up audits. Each of these audits was limited in size and only captured an average of 33 patient interaction moments. The small number of hand hygiene audits, and the limited nature of the audits which were completed, led us to conclude that Cape Breton was not doing enough to monitor and enforce compliance with hand hygiene policies. As discussed earlier in this Chapter, Infection Prevention and Control Nova Scotia noted the lack of infection control practitioner presence on patient units in Cape Breton as a concern. Regular hand hygiene audits help to ensure these practitioners visit patient units regularly.

Recommendation 4.24
Cape Breton District Health Authority should implement processes to ensure all hospital units have an initial hand hygiene audit and regular follow-up audits.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed a schedule and process for hand hygiene auditing that will ensure that all hospital units have both scheduled and random hand hygiene audits with regular follow up audits to ensure that improvements are evident and sustained.

Recommendation 4.25
Cape Breton District Health Authority should implement processes to ensure all hand hygiene audits are of sufficient size to ensure meaningful results.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed a plan to expand both its' auditing capacities and reporting capabilities to ensure that all units have sufficient hand hygiene auditing by a variety of auditors with a view to creating meaningful and accurate results that will inform decisions regarding culture improvement initiatives.

4.99 *Communication of audit results* – Capital Health infection control practitioners report the results of hand hygiene audits to those in charge of each unit; results are also posted on public bulletin boards in each unit and are available publicly on the District's website. The display includes a highly visible sign with the overall compliance rate for the unit, plus detailed results by staff category. It is useful because it is available to patients and their families. This is important as patients can have an impact on hand hygiene by asking health care workers if they have washed their hands.

4.100 Cape Breton does not post their hand hygiene audit results in any publicly visible location, but this information is provided to those in charge of a unit for discussion at staff meetings. The results are also reported in a District digest available to all staff. We noted there was no communication of hand hygiene audit results that easily reaches patients or their families. Failure to report these results so that patients can review them misses an opportunity to improve health care workers' hand hygiene through better-informed patients and families.

Recommendation 4.26
Cape Breton District Health Authority should post the results of its hand hygiene audits in a publicly visible location.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed a plan to post all hand hygiene audit results for all hospital units on the unit itself, the internal web site, the public web site and in designated public waiting areas for the public to view.

4.101 *Education* – Both Districts provided many examples of education materials and told us that they use the results of hand hygiene audits to direct this information to areas of higher need. District staff also showed us posters and pamphlets available throughout their hospitals for patients and visitors to review.

Hospital Acquired Infection Surveillance

Conclusions and summary of observations

While both Districts track an extensive list of hospital or health care acquired infections, neither has sufficient knowledge of the impact of those infections or of which infections are of most consequence to their District. Capital Health and Cape Breton both use case

definitions based on evidence-based best practice but we noted Cape Breton does not consistently apply its definitions. We also found that Capital Health does a better job of communicating infection rates to the people impacted by them.

4.102 *Policies* – Although both Districts have policies related to hospital acquired infections, most are outdated. As noted earlier, these policies are supposed to be reviewed every three years and updated as needed but this has not happened consistently.

4.103 *Case definitions* – Both Districts use definitions based on established best practice guidelines from organizations such as Health Canada or the Centers for Disease Control and Prevention in the United States. Although we had no concerns with the definitions used, the variety of sources supports the need for greater oversight by Health and Wellness to ensure that all district health authorities are using a consistent approach to monitor and track hospital acquired infections.

4.104 We tested cases recorded as hospital acquired MRSA, *C. difficile*, and ventilator associated pneumonia to determine whether these were properly classified. We did not test to determine whether the diagnosis of the disease was correct, but rather that the definition for hospital acquired MRSA, *C. difficile*, or ventilator associated pneumonia was met.

4.105 Due to differing infection rates in the hospitals we visited, our sample sizes vary from location to location. Different hospitals have experienced lower or higher rates of MRSA and *C. difficile* while some hospitals do not have ventilators and therefore did not have cases of ventilator associated pneumonia.

4.106 *Capital Health testing results* – We tested 30 MRSA files, 25 *C. difficile* files and 15 ventilator associated pneumonia files. 69 out of 70 files tested had sufficient evidence to support the District's conclusion that the patient had a particular hospital acquired infection. In one instance, the patient should not have been classified as a hospital acquired *C. difficile* case. This patient file was from 2009 and the patient had *C. difficile* when he or she arrived in hospital.

4.107 *Cape Breton testing results* – We tested 30 MRSA files, 30 *C. difficile* files, and 20 ventilator associated pneumonia files. We found that 25 of the 30 MRSA files tested met the definition. 25 of 30 *C. difficile* files tested met the definition. Only nine of 20 ventilator associated pneumonia files tested met the definition. Cape Breton management told us they are taking what they consider a more cautious approach to classifying this infection; they are not excluding all cases which do not meet the requirements to classify as ventilator associated pneumonia and will re-examine their methodology.

Recommendation 4.27
Cape Breton District Health Authority should implement a process to ensure the classification of hospital acquired infections is consistent with District policies.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed an improved process for documentation of hospital acquired infections on the paper multidisciplinary progress note and in our new Infection Prevention and Control Database as a component of routine surveillance activities by IPCs. Classification is determined utilizing the best practice case definitions for designated hospital acquired infections that are reviewed annually and approved by the Infection Control Committee.

4.108 *Timeliness* – Capital Health tracks infection rates on a daily basis, with each infection control practitioner responsible for monitoring infections on their units. Cape Breton infection control staff told us they track infection rates retrospectively at month end. They spend a significant amount of time and effort attempting to tabulate the information, but are often late with this reporting. This delayed surveillance may allow outbreaks to go unrecognized for longer periods. In addition, the time infection control practitioners spend tabulating the statistics might be better spent visiting hospital units.

Recommendation 4.28
Cape Breton District Health Authority should develop a more efficient and timely surveillance approach for hospital acquired infections.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and is developing an improved surveillance program that will soon be supported by electronic laboratory results summary reporting (requested from HITS-NS on July 29, 2011) as well as a newly developed internal Infection Prevention and Control database. The program will be based on best practices outlined in relevant Ontario PIDAC (Provincial Infectious Diseases Advisor Committee) documents.

4.109 Cape Breton infection control practitioners told us that they do not visit units regularly, whether for surveillance, audits or on routine rounds. Even when new hospital acquired infections are identified on a particular unit, practitioners often phone the unit to ask whether appropriate precautions are in place rather than visiting in person.

4.110 Many of the facilities in Cape Breton are in rural areas. Infection control practitioners told us that they rarely visit some of these facilities from November to April of each year, relying instead on phone calls to facility staff. We believe practitioners could maintain a presence in these facilities during winter months by monitoring the weather and timing visits accordingly.

4.111 This is another instance in which Cape Breton's infection control practitioners are not visible on patient units or in the facilities they are responsible for.

4.112 *Analysis performed* – Cape Breton and Capital do not have a complete analysis of the hospital acquired infection data collected, although both are attempting to monitor

for trends and outbreaks. Neither District is tracking morbidity or mortality rates associated with hospital acquired infections and neither has done any analysis of the costs associated with these infections, either to the patient or to the health care system.

4.113 Capital Health completes high level analysis of morbidity and mortality impacts for all areas within the District. This is done through its quality monitoring program and not connected to infection prevention and control. The rates for infections during our audit period were such that Capital Health management determined no further investigation was necessary.

4.114 Capital Health told us that they do track the isolation days and the costs associated with semi-private versus private rooms, but this is done from a billing perspective, not for infection control purposes.

4.115 One of Cape Breton's infectious disease doctors did a small research study in 2010 to assess the relative costs of treating a hospital acquired infection versus the costs of preventing the infection. While this was a small study, the results showed the costs of preventing hospital acquired infections were considerably lower than treating patients with these infections.

4.116 *Communication of hospital acquired infection rates* – Capital Health is doing a much better job of communicating rates to staff, service providers, volunteers, patients, families and visitors. Infection rates are posted on publicly-visible bulletin boards on patient units and are available publicly on the District's website. As noted, Cape Breton does not use public bulletin boards, instead posting the information on their intranet and encouraging staff to review it. Subsequent to our audit we noted that Cape Breton began posting infection rates on its website. While this is an improvement, posting this information directly in the unit would be more visible to patients and families at the time they are in hospital.

Recommendation 4.29
Cape Breton District Health Authority should improve its communication of hospital acquired infection rates by posting information in areas which health care workers, patients and families or visitors can easily access.

Cape Breton District Health Authority Response:
CBDHA accepts and agrees with this recommendation and has developed a new internal Infection Prevention and Control Database that will eliminate manual rate calculation and facilitate accurate and efficient report preparation for defined hospital acquired infection rates. Since December 2011, District rates have been posted on the public web site. Reports will also be posted monthly on patient care units, the internal web site and designated public areas in hospitals illustrating unit specific as well as site and District rates.

4.117 *Province-wide trends* – Neither District is monitoring province-wide trends in other district health authorities, or trends for similar infections occurring in other non-health facilities in their own districts. Similarly, Health and Wellness does not have any information on the incidence of infectious diseases and hospital acquired infections in the province.

4.118 Both Districts told us that the lack of a provincial surveillance system means there is virtually no ability to monitor possible trends or to identify hospitals with outbreaks so that patient transfers from those facilities can be treated with appropriate caution. Through Infection Prevention and Control Nova Scotia, the Department of Health and Wellness should lead the development of a surveillance system. Recommendation 4.1 earlier in this Chapter covers this issue.

4.119 *Role of infection control* – This audit illustrates the importance of infection prevention and control in limiting and controlling serious outbreaks of infectious diseases. As Government moves forward with attempting to reduce costs in health care, we understand that infection control has been included as an administrative service, rather than a patient care service. This could potentially lead to more significant cuts to infection control programs in the future. The results of this audit show the impact a poorly run infection prevention and control program can have in a district. Significant reductions to an infection prevention and control program are likely to result in negative impacts for patients and for overall health budgets as the system cares for patients with hospital acquired infections.

Cape Breton District Health Authority Additional Comments

The Cape Breton District Health Authority accepts the recommendations in this audit report and has taken steps to implement changes. The findings in this report are consistent with the previous reports released by the District. Following the initial *C. difficile* outbreak in 2011, steps were taken to increase the number of infection control practitioners and reorganize the service in order to be more effective. Further additions to infection control practitioner staff to bring the District to best practice levels have also been implemented. These additional resources represent an 86 percent increase over pre 2011 levels of staffing.

In late summer 2011, the District completed an assessment of sterile processing practices and was in the process of implementing changes recommended from this review at the time of the Auditor General's study. The commitment of additional resources to infection control at a time of restrained health care funding, the review initiated prior to the Auditor General's visit and the transparency in releasing all of the reports completed on the outbreaks demonstrate the District's commitment to improving its culture of infection prevention and control as well as sharing the lessons learned from our experiences with other health care organizations.

While acknowledging that a review of events always identifies opportunities for improvement, the District does not accept the premise that the District's response to the outbreaks was not effective. The report of the Public Health Agency of Canada clearly demonstrates that action in response to the outbreak resulted in a significant reduction in the transmission of *C. difficile* in District hospitals. Subsequent to the declaration of the second outbreak, specialized laboratory testing identified that the three patients diagnosed with *C. difficile* in the Intermediate Care Unit at the Cape Breton Regional Hospital had three different and distinct strains of the disease signifying that the transmission did not occur on this unit. Case review of the three patients diagnosed with *C. difficile* on 4B identified a single room as a common factor. It is important to note that in both of these units no further transmission to other patients occurred.

The District acknowledges the need to improve and strengthen its culture of infection control with significant focus on preventative issues starting with improvements in hand hygiene. The District has also introduced an antimicrobial stewardship program as reduction and improved use of antibiotics has been demonstrated to reduce the potential for *C. difficile*.

The District thanks the Auditor General staff for their input into the identification of areas to further enhance and strengthen infection control as part of an overall strategy to enhance patient safety.

Capital Health Additional Comments

Capital Health accepts the recommendations as outlined in this report. From Capital Health's perspective, it is important to stress that:

1. access to a very strong co-leadership team of an infection control manager and physician experts in infectious diseases;

2. employment of a dedicated team of infection control practitioners; and

3. senior leadership and organization wide commitment to continuous quality improvement, patient safety and overall quality;

are key to an effective infection control and management program.

Department of Health and Wellness Additional Comments

Although no provincial surveillance system is in place at this time, IPCNS has made some progress in data collection for healthcare-associated infections (HAIs). IPCNS has collaborated with Public Health in the process of making *Clostridium difficile* a notifiable disease as of April 1, 2012. This requires all *Clostridium difficile* isolates to be reported provincially to Communicable Disease Control, Public Health Services. IPCNS has been designing the data collection process to identify HAIs in conjunction with district-based infection control practitioners (ICPs) and Public Health.

Additionally, during the large *Clostridium difficile* outbreak in Cape Breton District Health Authority, IPCNS was monitoring the outbreak on a daily basis with case reports submitted by the Cape Breton District Health Authority. Given the Department's intimate involvement in that outbreak, IPCNS drafted a 'Lessons Learned" document (available publically) to share some of the findings and important mitigation strategies that were required to bring the outbreak under control, with other DHAs.

The Department appreciates the thorough review by the Auditor General on infection prevention and control. The Department agrees with all of the recommendations pertaining to the Department and recognizes the importance of accountability in its relationship with the DHAs. Over the next year, the Department will develop and enhance existing measures for monitoring and evaluating the districts' compliance with standards of care and Department expectations.

NOVA SCOTIA

Appendix 1

Infection Prevention and Control Nova Scotia – Recommendations from *A Report on Lessons Learned Following a Clostridium difficile Outbreak in Acute Care*

Following the *C. Difficile* outbreak at Cape Breton District Health Authority in early 2011, Infection Prevention and Control Nova Scotia produced a report titled *A Report on Lessons Learned Following a Clostridium difficile Outbreak in Acute Care*. This report included a number of recommendations; some were directed to the District, while others had broader applicability. We have reproduced these recommendations below for information purposes.

1. Develop the IPAC program that meets the mandate and goal of decreasing the risk of health care-associated infections and improving health care safety. This should be in line with the District mandate and reviewed yearly with a multidisciplinary infection prevention and control committee. It should include annual goal-setting, program evaluation and ensuring that the IPAC program meets current legislated standards and requirements as well as the requirements of the facility.

2. The District has increased ICP FTE position by 1.5; however it should continue to increase the FTE compliment to meet the needs of the IPAC program.

3. Require all ICPs to obtain Certification in Infection Control, within two to five years of hire. This should be included in the job description.

4. Ensure that ICPs maintain their knowledge and skills through continuing education relevant to their professional practice and recertification in infection control every five years.

5. Facilitate ICPs' active participation in professional activities at the provincial and national levels of CHICA NS and CHICA Canada.

6. Increase visibility of ICPs on their respective units. Daily rounds will enhance relationships between infection control and the clinical unit.

7. Conduct regular and ongoing educational programs for healthcare providers (including volunteers, family members and students) to reinforce current best practices of infection prevention and control, emphasizing the importance of hand hygiene.

8. Review and revise surveillance practices for data collection, collation, analysis, and reporting to ensure timely and efficient identification of trends can be detected. Ideally, surveillance should be facility-based, i.e. each ICP conducting surveillance of hospital acquired infections in the facilities they are responsible for.

9. Develop a process to store data so that it can be accessed and reviewed by ICPs in the various sites. Consistent documentation storage on a secure shared drive will facilitate this process.

10. Ensure the use of line listing occurs at the outset of an outbreak to better monitor cases, patient movement, and trends.

11. Ensure reporting of surveillance information to the involved services/programs and hospital administration in a format that is easily understood.

12. Consider reporting surveillance data as part of the hospital score card for quality and patient safety on the public web site in an understandable and easy to access format. This will improve transparency and confidence in the hospital.

13. Ensure infection control practitioners perform ongoing audits (hand hygiene, adherence to additional precautions, environmental, and construction-site audits) and daily rounds of all hospital sites, either in person or by phone. Regularly scheduled visits to rural sites will

Infection Prevention and Control Nova Scotia Recommendations (continued)

increase visibility and provide opportunities to deliver targeted education to healthcare staff. Use of technology may assist in virtual visits to more remote rural sites when travel is difficult.

14. Provide opportunities for ICPs to expand their technical expertise, particularly in the area of reprocessing and construction/renovation-related auditing. Gaps in knowledge should be identified and a plan developed to facilitate closing the knowledge gap.

15. Outbreaks should be managed by a multidisciplinary team that includes the ICP team. Delegate legitimate authority to the ICP to implement prompt outbreak management measures.

16. Ensure Infection Prevention and Control has input in product procurement and evaluation, coordination with safety, and other quality assurance initiatives. It is imperative that they be involved at all stages of facility design and renovation and have the authority to halt projects if there is a risk to client/patient/resident or staff safety. Selected finishes should be able to withstand frequent exposure to hospital-approved disinfectants, be water impermeable and easily cleaned.

17. Non-intact furnishings and surfaces identified by staff and through environmental audits should be repaired or replaced.

18. Ensure that:
    a) Commode chair is dedicated to the patient/resident;
    b) Commode is cleaned and disinfected whenever the room/bathroom is cleaned;
    c) When precautions are discontinued, dedicated commodes and bedpans are cleaned and disinfected before use with another patient/resident;
    d) Items used to clean the bathroom of a patient/resident with CDI must be dedicated to that bathroom and discarded once Contact Precautions are discontinued (e.g., toilet brush)

19. Ensure removal or decommissioning of spray wands in patient bathrooms and soiled utility rooms. It is acknowledged that CBDHA immediately disconnected the taps of the wands upon receiving this recommendation from IPCNS.

20. Develop and enforce a strict process for bedpan/commode waste management to prevent further splashing and contamination of the environment. The process should utilize the soiled utility rooms or consider alternative management strategies that do not result in unnecessary environmental contamination of patient's toileting room. Installation of bedpan flusher/disinfectors may be considered a viable alternative.

21. Dedicated hand washing sinks should be available for staff to wash their hands. Hand hygiene should not be carried out at a patient sink as this will recontaminate the health care worker's hands. A plan should be developed in consultation with nursing staff and ICPs to determine the most appropriate locations for hand washing sinks to ensure they correlate with work flow practices.

22. Audit and observe meticulous hand hygiene with either soap and water or alcohol-based hand sanitizer (ABHS). Soap and water is theoretically more effective in removing spores than ABHS but if a dedicated sink is not immediately available ABHS is a reasonable alternative.

23. Provide education to staff and patient's on the need and procedure to be used for hand hygiene (i.e., The 4 moments for hand hygiene).

24. Ensure continuance of environmental audits. These should be carried out using a standard checklist and all audit results should be documented and analyzed. Audit results should

Infection Prevention and Control Nova Scotia Recommendations (continued)

be shared and reviewed with environmental services staff as part of ongoing professional development.

25. Engage IPAC in the selection and purchase of cleaning and disinfectant products. A system that utilizes automated dispensing/dilution technology may streamline the process of mixing for staff eliminating any room for error with dilution ratios. All environmental services staff should receive in-depth education of both the cleaning chemistries they are using and the best practices for cleaning and disinfection.

26. Develop detailed checklists for environmental services staff to use during outbreak and non-outbreak times.

27. The proper cleaning of a *C. difficile* room involves twice daily cleaning and disinfection using a hospital approved cleaning and disinfection agent. The timing of the cleaning should be spaced as much as possible to improve the effectiveness of this process. A sporicidal agent should be used twice daily in the patients bathroom.

28. If an outbreak is suspected or confirmed switching to a sporicidal agent should be considered and used throughout the rooms of patients with suspected or confirmed CDI. It is important to note that bleach is not a cleaning agent and therefore if this is the selected sporicidal agent, cleaning must still be done using a compatible approved hospital cleaning and disinfection agent prior to application of bleach (this applies to #26 above).

29. When otherwise unexplained new onset of diarrhea occurs, those patients should be immediately placed on contact precautions while awaiting investigations to determine the cause.

30. Make every effort to minimize the amount of in-house and between-site transfers of symptomatic, isolated patients.

31. During an outbreak, it is strongly recommended not to manage patients with confirmed *C. difficile* in the same room as patients who do not have the infection.

32. A single room with dedicated toileting facilities (i.e., private bathroom or individual commode chair) is preferred. In instances where a patient is unable to be accommodated in this manner, priority should be given to patients who are fecally incontinent. If a symptomatic patient is in a multi-bed room, the patient should be provided a dedicated commode chair which must be emptied in a dedicated site (i.e. soiled utility hopper, bed pan flusher/disinfector) to avoid contamination of the environment. The stool must not be discarded in a washroom used by other patients.

33. Cohorting lab-confirmed cases with other lab-confirmed cases is an acceptable approach however placement should always be done under the direction of the ICP.

34. Initiate a formal and inclusive outbreak management team which will meet frequently, if not daily to assess outbreak data and update team on status of interventions. The Outbreak Management Team (OMT) directs and oversees the management of all aspects of an outbreak.

35. Ensure representation from the following: ICPs, Infectious Disease physician, if available, senior administration and appropriate hospital departments (i.e. environmental services, pharmacy, laboratory, purchasing, bed utilization/discharge planner personnel, Occupational Health, public relations/communications staff to handle media inquiries, etc.). It is important that representatives on OMT have decision-making power, particularly the ICP to direct practice changes of an infection prevention and control nature.

Infection Prevention and Control Nova Scotia Recommendations (continued)

36. Through a multidisciplinary approach, including pharmacy, physicians, technological support, medical microbiology, infection prevention and control, and clinical resource nursing, implement an antibiotic stewardship program ensuring targeted antimicrobials meet the local epidemiology and strains present.

37. In patients with CDI, consideration needs to be given to changing the implicated antibiotic(s) to antimicrobial agent(s) felt to pose a lower risk for CDI. Nonessential antibiotics must be discontinued. Other elements of management include the avoidance of prescribing antimotility agents and the prompt institution of supportive care (i.e. hydration and electrolyte replacement).

    To identify the specific agent to use in the treatment of CDI, the patient should be evaluated to determine the severity of illness. The laboratory criteria that have been associated with more severe disease are a WBC count greater than 15,000 and/or a serum creatinine level greater than 1.5 the premorbid level, particularly in those over the age of 60 yrs. For mild to moderate disease, metronidazole is the recommended treatment. For those with severe disease, as determined by the clinical presentation and/or laboratory criteria, treatment with oral or nasogastric vancomycin is recommended. Those with more complicated disease (e.g. requiring ICU admission because of the CDI, shock, ileus and toxic megacolon) should have consultation with a physician experienced in treating CDI, as well as potentially surgical consultation. For further information, the Infectious Diseases Society of America (IDSA) provides guidance on the management of CDI infection on their website. (http://www.jstor.org/stable/10.1086/651706)

NOVA SCOTIA

5 Health and Wellness: Nova Scotia Prescription Monitoring Program

Summary

While some aspects of the Nova Scotia Prescription Monitoring Program are effective, there are significant weaknesses in the Program's control and monitoring processes that can allow abuse or misuse of prescription drugs to continue undetected. Improvements are needed to address these issues.

We found the Program's governance structure is adequate. Detailed oversight rests with the Prescription Monitoring Board; the Department of Health and Wellness is represented on this Board by two Department employees. The Board receives regular information from Medavie, the Program's contracted administrator. We are concerned that the Board appears to emphasize one aspect of its mandate, education, over active monitoring. The issues we identified during our audit show that the Board needs to do more to address its mandate related to promoting the reduction of abuse or misuse of monitored drugs.

While the Program's online system which pharmacists use to enter monitored drug prescriptions is a positive step, there are gaps in the system. Pharmacists can override the online system and dispense medication despite potential issues identified; the program does not track or monitor the results of these warnings. Additionally, monitored drugs dispensed to hospital inpatients or in emergency rooms are not entered in the online system and the Program has no information regarding these drugs.

The Program does produce regular reports to assess utilization of monitored drugs and individuals receiving prescriptions from multiple prescribers. However many situations identified in these reports are not followed up. We recommended the Program redesign its reports so that fewer items are identified, and most of those require further investigation. For those instances which were followed up, prescribers did not always meet Program deadlines for information. We also found the Program's medical consultant did not always review information in a timely manner and we recommended establishing deadlines which the medical consultant must meet.

We found Program staff do not document details of their review of drug utilization and multiple prescriber reports or the reasons for decisions reached. We identified many instances in which there was no evidence that appropriate action was taken when potential concerns were identified.

Controls over the Program's duplicate prescription pads need improvement. We recommended that the Program establish processes to ensure pads which have been reported as lost, stolen or forged are marked as void in the online system immediately.

5 Health and Wellness: Nova Scotia Prescription Monitoring Program

Background

5.1 The Prescription Monitoring Act was approved in October 2004; it was proclaimed along with the Prescription Monitoring Regulations in June 2005. A Prescription Monitoring Board (Board) was appointed to establish and operate the Nova Scotia Prescription Monitoring Program (Program). The Board reports to the Minister of Health and Wellness.

5.2 In 2005, Health and Wellness entered into an agreement with Medavie Blue Cross to administer certain provincial programs, including the Prescription Monitoring Program. As administrator, Medavie works with the Board to determine how the Program should function.

5.3 During 2010-11, the Program participated in several educational seminars and presentations and provided data on the prescribing and utilization of monitored drugs to various stakeholder groups including medical professionals, law enforcement and community groups. The Program's medical consultant is also available as a resource to prescribers.

5.4 The Program's objectives are *"to promote (a) the appropriate use of monitored drugs; and (b) the reduction of abuse or misuse of monitored drugs."* A monitored drug is defined as any drug that is a controlled drug in the schedules to the Controlled Drugs and Substances Act (Canada), with some exceptions.

5.5 The Board interprets its legislative mandate, including its mission, to be:

- *"educate prescribers, dispensers, and the general public on the appropriate use of monitored drugs;*
- *collaborate and develop working partnerships with other key organizations in order to achieve the Program's objects; and*
- *proactively share information in a timely and responsive manner to allow others to do their part in achieving the Program's objects."* (Source: Program website)

5.6 The Prescription Monitoring Board's interpretation of its mandate focuses on the dissemination of information through trend analysis, education and communication. We interpret promotion as involving taking action to achieve improvements in the areas of appropriate use of monitored drugs and reduction of abuse and misuse.

5.7 The Program's monitoring activities not only promote the appropriate use of monitored drugs, but also help to reduce misuse and abuse. Both the drug utilization

review and multiple prescriber reports achieve both of these objectives. We focused our audit largely on the monitoring activities the Board conducts, as these provided some coverage of all aspects of its mandate.

5.8 Prescriptions for monitored drugs are written on pre-numbered, duplicate prescription pads. The prescriber retains one copy of the prescription and the pharmacy retains the other copy.

5.9 The Program has an online prescription database. Pharmacists enter monitored drug prescriptions into the Program's online database before dispensing the drugs. This system also notifies pharmacists of potential issues such as a patient filling prescriptions for monitored drugs from several prescribers or a stolen prescription.

5.10 The database and its reports are intended to allow the Program to identify trends in the prescribing and utilization of monitored drugs and to intervene when necessary. Standard reports are generated which provide information on individuals who may be misusing or abusing monitored drugs. In some instances, prescribers receive letters asking for information regarding a prescription or the physician's prescribing practices. Responses are required within Program deadlines ranging between approximately two weeks and a month. Failure to provide a response can result in the prescriber being referred to the College of Physicians and Surgeons of Nova Scotia; the professional body responsible for regulating physicians in the province. These activities serve to address both the promotion and monitoring aspects of the Program's legislated mandate.

5.11 The Board has also established subcommittees.

- The Drug Utilization Review Committee considers drug utilization data to monitor the prescribing and utilization of monitored drugs and to identify unusual and potentially inappropriate trends.
- The Practice Review Committee provides peer review of physician's responses to Program inquiries regarding prescriptions.

5.12 The Program's volume and demand for its services have increased in recent years. The Program processed approximately 700,000 prescriptions in 2010-11, an increase of 36% since 2007-08. Prescribers, pharmacists, licensing authorities and law enforcement can request patient profiles from the Program outlining an individual's history of monitored drug purchases. The number of patient profile requests increased from 792 in 2007-08 to 1,643 in 2010-11.

5.13 The abuse of prescription opiate medication has received considerable media attention due to overdoses and deaths in the province attributed to monitored drugs in recent years. While the Program covers certain avenues to obtain monitored drugs, there are other legal sources that fall outside the Program, such as monitored drugs dispensed to hospital inpatients or through emergency rooms. Additionally, there are many potential illegal sources of monitored prescription drugs.

Audit Objectives and Scope

5.14 In early 2012, we completed a performance audit of the Nova Scotia Prescription Monitoring Program to assess whether the Program adequately monitors the prescribing and utilization of monitored drugs and takes appropriate action when potential abuse is identified. We did not examine all the work completed by the Program. The specific education initiatives undertaken by the Program to promote appropriate use of monitored drugs are lower risk. We chose to focus our work on the Program's monitoring of the prescribing and utilization of monitored drugs as these were the highest risk areas. However, the monitoring activities the Program engages in not only help to reduce misuse and abuse, but also educate stakeholders and promote appropriate usage.

5.15 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

5.16 The objectives of this audit were to assess:

- the adequacy of the Department of Health and Wellness' oversight of the Program;
- compliance with the contract between the Province and Medavie Blue Cross to administer the Program;
- the adequacy of the Board's governance of the Program;
- whether the Program is adequately monitoring the completeness, accuracy and timeliness of monitored drug prescription information received from pharmacies;
- whether the Program is adequately monitoring the prescribing and utilization of monitored drugs and taking timely and appropriate action when trends or possible abuses are identified;
- whether the Program has adequate controls over the storage and issuance of duplication prescription pads; and
- whether there is an adequate process to respond to lost, stolen or forged duplicate prescription pads.

5.17 Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed by our Office specifically for this engagement. These criteria were discussed with, and accepted as appropriate by, senior management at the Department of Health and Wellness and the Prescription Monitoring Program and Board.

5.18 Our audit approach included an examination of legislation and the Program's monitored drug prescription information. We tested compliance with selected policies and conducted interviews with management and staff. Our audit period covered April 1, 2009 to October 31, 2011.

Significant Audit Observations

Program Oversight

Conclusions and summary of observations

The Prescription Monitoring Program's governance structure is adequate. Detailed oversight of the Program rests with the Board; two employees of the Department of Health and Wellness are Board members and can represent the Department's interests. Medavie Blue Cross administers the Program on behalf of the Board; we found the Board regularly monitors Medavie's compliance with its obligations. Although Health and Wellness told us that hospitals are supposed to review monitored drugs prescribed to inpatients and those in emergency, only one district health authority was able to provide the Prescription Monitoring Program with any information. We recommended this gap in reviewing legal sources of monitored drugs be addressed.

5.19 *Board structure* – The Board is comprised of 10 members, including the registrar from each of the College of Physicians and Surgeons of Nova Scotia, Nova Scotia College of Pharmacists, and the Provincial Dental Board of Nova Scotia, plus one additional member appointed by each of these bodies, along with two public members appointed by Health and Wellness and two nonvoting members from the Department. During our audit period, the Board was missing one of its two public members.

5.20 The two Health and Wellness employees can provide input and represent the Department's interests; however, beyond this arrangement there is limited reporting between the Board and the Department. The Department receives information on the Program's activities and the utilization of monitored drugs in the Province through business plans and annual reports.

5.21 *Committee structure* – The Board established the following committees to assist in administering the Program and identifying and evaluating possible abuse or misuse of monitored drugs.

- An Executive Committee to discuss urgent matters that may arise between Board meetings
- A Drug Utilization Review Committee to review aggregate monitored drug prescription data to identify potentially inappropriate trends
- A Practice Review Committee to provide peer review of the responses to drug utilization review inquiries

5.22 We reviewed Board minutes and found that the Board is reviewing information received from its committees.

5.23 During our audit period, each committee had a full complement of members and was meeting at an appropriate frequency.

5.24 There was adequate attendance at meetings of the Board and Practice Review Committee; however attendance at Drug Utilization Committee meetings was poor. The Committee did not have a full complement of members at any of its ten meetings during our audit period. At three of those meetings, less than half of the committee members attended. The Board seeks practicing clinicians to participate as committee members and this can cause challenges since these individuals also see patients. Program management and the Board told us they are attempting to address this issue through recent membership changes.

5.25 *Contract with administrator* – In 2005, the Department of Health and Wellness entered into a contract with Medavie Blue Cross (Medavie) to administer certain provincial programs, including the Nova Scotia Prescription Monitoring Program. The contract clause related to the Program is very brief and does not outline the responsibilities of each party. Instead, it calls for a separate agreement to document Medavie's service delivery obligations. Health and Wellness gave the Nova Scotia Prescription Monitoring Board responsibility for developing and monitoring these obligations. Although the Board developed a service obligation agreement with Medavie, Health and Wellness should have established the expectations of both parties before signing a contract. Failure to do so is a poor business practice; once a contract has been signed, there is no assurance government will be able to reach an agreement with an external service provider.

5.26 *Medavie's service obligations* – The Board and Medavie signed a service obligation agreement outlining Medavie's responsibilities. The Board monitors compliance with the service obligations and legislative requirements through a report which Medavie submits at each Board meeting. Legislative requirements are also monitored through the Board's review of the Program's annual report. Overall, the Board is doing a good job of overseeing Medavie and the Program at a high level, however as discussed later, we are concerned that there are significant gaps in the Program's control and monitoring processes.

5.27 We did identify one instance of noncompliance with the service obligations; there is no ad hoc committee to review the list of monitored drugs. However the Board does discuss changes to the list at meetings as necessary. Management told us that this committee has not been established because only the Minister can approve changes to the monitored drug list, which is based on the federal Controlled Drugs and Substances Act and regulations. Any changes to federal act and regulations would be reflected in the list used by the province.

Recommendation 5.1
The Nova Scotia Prescription Monitoring Board and the Department of Health and Wellness should review and amend the service obligations agreement with Medavie Blue Cross to address any requirements which are no longer relevant.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. By the end of 2013, the three parties will review the Service Obligations Agreement in conjunction with changes made to move the prescription capture function into the provincial Drug Information System (DIS). This timing will ensure the Service Obligation Agreement does not include requirements that will be assumed by the DIS.

Nova Scotia Prescription Monitoring Board Response:
The NSPMP Board ("the Board") agrees with this recommendation and commits to collaborating with the Department of Health and Wellness (DHW) to review the Service Obligations Agreement by the end of 2013. The review process will take into account the functions and activities that will eventually be moved from the NS Prescription Monitoring Program (the Program) to the provincial Drug Information System (DIS) in 2013.

5.28 The Board completes an annual effectiveness survey to evaluate Medavie's performance against the Program's stated goals and objectives. We reviewed the survey results for 2009, 2010 and 2011; there were no issues identified with Medavie's performance.

5.29 *Monitoring gap* – The Program is not responsible for monitored drugs provided to patients discharged from hospitals or emergency rooms. Health and Wellness management told us that hospitals are supposed to monitor utilization of these drugs. However, when the Program asked district health authorities across Nova Scotia to provide statistics on opiate use for patients in hospitals, only one district was able to provide this information. Although Regulations to the Prescription Monitoring Act state that prescriptions are not required on duplicate forms for those in hospital, this does not mean it is not necessary to supervise monitored drugs dispensed through hospitals.

Recommendation 5.2
The Department of Health and Wellness should require hospitals in the province to provide regular reports of monitored drugs dispensed to patients when discharged from hospitals or emergency rooms, either directly to the Department or to the Nova Scotia Prescription Monitoring Program.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation and will examine the business requirements for this reporting with the District Health Authorities (DHAs) – including costing – so reporting of monitored drugs provided to patients/individuals when they leave hospitals or emergency rooms is in place by 2014.

Prescription Monitoring Information System

Conclusions and summary of observations

The Program's online prescription information system provides pharmacies with information on an individual's utilization of monitored drugs, as well as data for further Program monitoring. Although the system is a positive step towards examining the use of monitored drugs, we identified areas in which improvements are required. Pharmacists can fill prescriptions for monitored drugs without immediately entering the prescription in the online system; in these instances, the information is sent to the Program within 30 days. As a result, information is not available in a timely manner and we recommended that all pharmacists be required to enter monitored drug prescription information in the online system as soon as possible. While the system notifies pharmacists of potential issues such as obtaining prescriptions from several physicians, the Program does not monitor the effectiveness of these notifications to assess whether they impact the potential abuse or misuse of monitored drugs. We found the Program relies on pharmacy audits to verify that prescription information was entered in the system accurately. However not all pharmacies have been audited and improvements are needed to audit processes.

5.30 *Prescription Monitoring Program database* – The Prescription Monitoring Program has an online database which all pharmacies can access. When monitored drugs are dispensed, pharmacists enter the prescriptions into the database. The Program uses this information to monitor the prescribing and utilization of monitored drugs in Nova Scotia.

5.31 *Response codes* – The database uses response codes to provide immediate feedback and information to pharmacists regarding patients and their prescriptions. Response codes vary and include indicators that a patient is deceased, or that a patient has submitted another prescription for a monitored drug within the last 30 days. When a response code is received, the pharmacist must use professional judgment to determine whether to dispense the prescription.

5.32 Although there could be many situations in which a pharmacist might appropriately dispense a monitored drug after receiving a response code, we are concerned the Program is not tracking whether prescriptions are dispensed or canceled based on the response code. While these prescriptions may be dispensed legitimately, the Program could be monitoring long-term trends related to response codes to attempt to identify pharmacies which fall outside the normal patterns of dispensing. The results of such monitoring could be used to further educate pharmacists and to assist with the reduction of abuse or misuse of monitored drugs.

Recommendation 5.3
The Nova Scotia Prescription Monitoring Program should monitor and assess action taken based on response codes as a means to identify pharmacies which may require further follow-up.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department, in collaboration with the Board, will direct the Administrator to identify interim options to monitor and assess actions taken on response codes sent to pharmacies. The Board will work with the Administrator to determine the feasibility of the options, select one, and implement it by the end of 2013. Note that in 2013 the DIS will assume the prescription capture functions for the Program, and monitoring and assessment of response codes will be part of the system functionality.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation. Although the provincial DIS will eventually assume the prescription capture functions currently carried out by the Program, the Board will work in collaboration with the DHW to ensure the implementation, by the Administrator, as soon as reasonably possible, of quality assurance measures to monitor and assess actions taken on response codes to pharmacists.

5.33 *Alerts* – The Program also issues alerts to pharmacies and physicians for various matters including stolen duplicate prescription pads and possible situations in which an individual tries to obtain monitored drug prescriptions from more than one physician. During our audit period, 18 alerts were issued, the majority of which related to stolen duplicate prescription pads. One alert during our audit period related to attempts to obtain monitored drugs from several prescribers.

5.34 Medavie regularly provides alert information to the Board. However, as with response codes, the Program does not monitor the effectiveness of the alerts it issues. Monitoring is important to confirm whether alerts are an effective tool to promote appropriate use and reduce misuse and abuse of monitored drugs.

Recommendation 5.4
The Nova Scotia Prescription Monitoring Program should monitor the effectiveness of its alerts to physicians and pharmacists and report the results to the Board.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department, in collaboration with the Board, will direct the Administrator to identify indicators that could be used to measure the effectiveness of alerts and propose options for measuring these indicators that can be implemented in 2013.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and commits to working with the DHW in directing the Administrator to, with the assistance of experts, identify a mechanism and indicators for monitoring the effectiveness of its alerts to physicians and pharmacists and to commence measuring these indictors as part of its ongoing quality assurance activities in 2013.

5.35 *Lack of timely information* – Pharmacists are supposed to enter prescription information into the online system immediately. However, if the system is not available, the pharmacist is permitted to dispense the monitored drug provided the prescription is submitted to the Program within 30 days. When prescriptions are not entered immediately, resulting delays can reduce the effectiveness of the response codes sent to pharmacists. Potential issues, such as multiple prescriptions for the same monitored drug or a patient receiving monitored drug prescriptions from more than one physician, may not be identified until long after the medication has been dispensed. This problem could be avoided if pharmacists were required to enter information regarding monitored drugs dispensed when the system is not working as soon as the system becomes available.

Recommendation 5.5
The Nova Scotia Prescription Monitoring Program should require pharmacies to enter prescription information for monitored drugs dispensed when the system is not working as soon as the system becomes available.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The DIS will address this issue when it assumes the prescription capture functions for the Program. In the interim, the Department will direct the Board to require the Administrator develop and implement a policy that addresses this issue by the end of 2012. The Department will follow up with the Board in 2013 to ensure compliance.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation. Although the provincial DIS will eventually assume the prescription capture functions currently carried out by the Program and will address this matter, the Board will direct the Administrator to develop and implement an interim policy by the end of 2012.

5.36 *Pharmacy audits* – In 2009, the Program began pharmacy audits to monitor the quality of prescription information received. If prescription information is not entered accurately or in a timely manner by pharmacists, this impacts the Program's ability to identify possible instances of inappropriate prescribing, abuse or misuse of monitored drugs. Pharmacy audits are primarily intended to ensure all prescriptions have been submitted to the Program. The audits also address whether all prescriptions in the online database are supported by original prescription slips, and whether detailed Program information agrees to original prescriptions. Program staff assess whether a pharmacy passes or fails an audit. The current pass rate is 90%; prior to 2011 it was 75%.

5.37 Each pharmacy is to be audited at least once every two years to determine if prescription information submitted is complete, accurate and timely. Our audit period covered 31 months and we found 31 pharmacies were not audited during that time. When the audit process was first implemented, scheduling was based on the Nova

Scotia College of Pharmacists' audit process because the Program obtained certain pharmacy information from the College. Management told us that the Program now obtains this information directly from the pharmacy, allowing the Program to set its own schedule. Management are hopeful this will allow the Program to meet its two-year target in the future.

Recommendation 5.6
The Nova Scotia Prescription Monitoring Program should conduct audits of all pharmacies registered with the Program at least once every two years.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation and notes that the Program already conducts audits of all registered pharmacies at least once every two years. The Department will direct the Board to monitor these audits to ensure compliance by 2013. The Department will follow up with the Board in 2013 to confirm compliance.

Nova Scotia Prescription Monitoring Program Board Response:
The Board agrees with this recommendation. This policy is currently in place.

5.38 If a pharmacy fails its first audit, a second audit is completed. However, this covers the same overall time period as the first audit, and the results are considered in isolation from the initial audit. If the pharmacy passes the second audit, no further steps are taken. While testing additional sample items is a reasonable approach when issues are identified, the final audit conclusion should be based on all sample items tested throughout the period, and the determination of whether the pharmacy passes the audit should depend on the results of all items tested.

Recommendation 5.7
The Nova Scotia Prescription Monitoring Program should change its audit process to base final conclusions on all items tested during the audit period.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Program has based its final audit conclusions on all items tested during the audit period. The Department will direct the Board to monitor these audits to ensure compliance by 2013. The Department will follow up with the Board in 2013 to confirm compliance.

Nova Scotia Prescription Monitoring Program Response:
The Board agrees with this recommendation and will ensure that the Administrator's audit process will include this methodology by the end of 2012.

5.39 We selected a sample of 20 audits in which the pharmacy received a failing score. We found nine of the 20 pharmacies failed two consecutive audits while three pharmacies failed three consecutive audits.

5.40 The Program may refer a pharmacy which fails an audit to the Nova Scotia College of Pharmacists. Six pharmacies included in our sample were referred to the College at some point during the Program's audit process. Three were referred after an initial audit, two were referred to the College after failing the second audit, and one was referred after failing a third consecutive audit.

5.41 The decision to refer a pharmacy to the Nova Scotia College of Pharmacists following a failed audit will depend on various factors and sometimes involves discussion with the College. Our sample included four instances in which follow-up audits were conducted after a pharmacy had been referred to the College of Pharmacists. In three of these cases, the pharmacy received a passing score on the subsequent audit. Although this relates to a small number of cases, referring pharmacies to the College of Pharmacists appears to be an effective way to improve compliance with Program requirements.

Prescription Monitoring Processes

Conclusions and summary of observations

The Program has processes to monitor the prescribing and dispensing of monitored drugs but there are considerable weaknesses that allow potential abuse or misuse to continue undetected. Drug utilization review and multiple prescriber reports are not effective; each report identifies many possible issues but a very small number are followed up. There is no support to confirm that all situations identified in the reports were appropriately reviewed; we could not tell why cases were closed or flagged for further investigation. We identified instances in which the Program failed to take appropriate action when potential concerns were identified with the prescription and utilization of monitored drugs. Additionally, a methadone program was accidentally excluded from monitoring reports for 21 months.

5.42 *Reports* – Drug utilization review intervention reports are generated every 56 days to identify those individuals who received a medication dosage in excess of an established threshold. Reports are reviewed to identify instances which may suggest inappropriate prescribing, abuse or misuse. For situations identified as requiring follow-up, an automated letter is sent to the prescriber requesting an explanation for the medication and dosage prescribed. Responses are assessed for reasonableness. If uncertainty exists regarding the response, additional information may be requested or the Program's medical consultant may be contacted. If Program staff are satisfied with the prescriber's response, the case is closed with no further action required.

5.43 Multiple prescriber reports are generated every 28 days to identify individuals who have received prescriptions from three or more prescribers. If it appears a patient may be trying to inappropriately obtain prescriptions for monitored drugs from more than one prescriber, staff may send letters notifying prescribers of this activity. These letters are sent for information only; prescribers are not required to provide a response to the Program.

5.44 *Thresholds* – Currently, both drug utilization review and multiple prescriber reports are very large.

- The drug utilization review reports averaged 2,000 situations identified as exceeding thresholds; only 2% of these cases resulted in letters to prescribers and further analysis.
- The multiple prescriber reports averaged 215 situations identified, with notification letters sent in 13% of these cases.
- In many instances, the same individuals are flagged on these reports regardless of whether their circumstances have changed. This includes instances in which a prescriber has already given the Program a reasonable explanation, and instances in which Program staff previously determined a letter was not necessary.

5.45 One person is responsible for the review of both drug utilization and multiple prescriber reports. We were told this review takes approximately three days to complete. With an average of 2,000 situations identified on each drug utilization report, most cases can only receive a very brief review. Furthermore, the size of the reports greatly increases the risk of human error. We are concerned whether a thorough and consistent review of each case can be completed. We found a drug category was mistakenly excluded from the drug utilization review for three consecutive reports during our audit period. The previous seven drug utilization review reports flagged approximately 2,100 cases. This dropped to roughly 1,300 for three reports, a decline of 40%. While these errors were eventually detected by Program staff, the exclusion of a drug category, and resulting 40% decline in the size of the reports, should have been detected immediately. The fact that this went unnoticed for three reports further highlights the challenges with manually reviewing large reports.

5.46 Program staff's review of the drug utilization report is a key monitoring activity used to identify trends to guide education and promotion of appropriate use, and trends indicating possible instances of inappropriate prescribing and potential abuse or misuse of monitored drugs. The reports are generated based on a single variable comparing the prescribed medication dosage to the Program's threshold for each drug category. Program staff told us that there are other factors which are considered as reports are reviewed in determining whether follow-up is necessary. Similarly, multiple prescriber reports are generated based on the number of prescriptions the individual has received during the report period, but the manual review of these reports considers several other factors.

5.47 Very few letters are issued relative to the number of cases flagged in each report. This suggests that either the thresholds are flagging many acceptable prescriptions, or the review process is failing to identify many problem cases. The Program needs to better utilize technology to target several variables representing the more significant risks and ensure the majority of cases flagged require further follow-up. This would reduce the likelihood of human error associated with manually reviewing large

volumes of data as well as make better use of limited Program resources than the current intensive manual review process.

5.48 We also found report thresholds are not reviewed on a regular basis. Program staff told us that the drug utilization review report thresholds are currently under review, although there is no timeline for completion. This review of thresholds should be conducted in conjunction with establishing additional variables for reports as discussed above and should be linked to best practices where possible.

Recommendation 5.8
The Nova Scotia Prescription Monitoring Program should redesign its drug utilization review and multiple prescriber reports to better use technology and reduce the reliance on manual review. The Program should aim to develop reports in which the majority of items flagged require further follow-up.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to undertake a complete revision of the Program's drug utilization review process. The Board's Drug Utilization Review Committee, along with the epidemiological expertise of the newest Departmental representative on the Board, can assist the Administrator in building a new drug utilization review framework based on internationally established evidence and validated indicators. The review is expected to be complete in 2013 with implementation in 2014. The Department will monitor progress toward completion of this initiative.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to, as part of its quality assurance activities and with the assistance of experts, undertake a comprehensive review of its drug utilization review process in 2013 and implement the resulting updated review framework/process in 2014.

5.49 *Concerns with report review process* – Although the Prescription Monitoring Program has established criteria to review drug utilization and multiple prescriber reports and identify items for follow-up, we found the criteria are poorly defined. Additionally, staff reviews of these reports are not linked to criteria. Although it is clear that Program staff review drug utilization and multiple prescriber reports, there is no support for how they determine which cases should be followed up, and no evidence to document the review. The only evidence is a notation in the Program database for those cases in which a letter was sent.

5.50 *Lack of consistency* – We analyzed the data from the drug utilization reports during our audit period and found there was no consistent pattern to the situations for which letters were sent. We identified many instances in which a letter was sent when someone was one to two percent over the threshold; conversely, there were also many instances in which letters were not sent when an individual was prescribed 10 to

20 times the dosage threshold. While Program staff were able to provide possible explanations, there was no documentation to confirm this was the rationale considered when the cases were reviewed. Given these inconsistencies and the absence of any documentation supporting why cases were identified for follow-up, it is impossible to know whether all situations were followed up or whether the action taken was appropriate.

5.51 *Testing* – We reviewed the 17 drug utilization reports and 34 multiple prescriber reports prepared during our audit period and selected samples from each to determine whether decisions reached were supported.

5.52 We were unable to determine why cases were identified for further follow-up or why other situations were deemed acceptable. Since there is no documentation of the review, staff were only able to provide potential reasons for actions taken. Additionally, one of the items we identified for testing had been reviewed by a staff member who is no longer with the Program. The current staff member responsible for reviewing these reports felt a letter should have been sent, but because there is no documentation, was unable to explain why this situation was not followed up. Adequate documentation of the review, along with the reason for final decisions, is necessary to ensure all cases receive an appropriate review and are treated consistently.

5.53 We also found there is no independent review of staff's assessment of drug utilization and multiple prescriber reports.

Recommendation 5.9
The Nova Scotia Prescription Monitoring Program should document support for all decisions made during the review of the drug utilization review and multiple prescriber reports, including decisions regarding whether to follow-up and whether responses are acceptable.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to undertake a complete revision of the Program's drug utilization review process. The Board's Drug Utilization Review Committee, along with the epidemiological expertise of the newest Departmental representative on the Board, can assist the Administrator in building a new drug utilization review framework based on internationally established evidence and validated indicators. The review is expected to be complete in 2013 with implementation in 2014. The Department will monitor progress toward completion of this initiative.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to include documentation policies and mechanisms that will support all decisions made during the drug utilization review process as part of the updated drug utilization review framework/process noted in the response to Recommendation #8, with an implementation date of 2014.

Recommendation 5.10
The Nova Scotia Prescription Monitoring Program should implement a quality assurance process to review the adequacy and appropriateness of the work completed by staff on the drug utilization review and multiple prescriber reports as well as other Program reports.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to undertake a complete revision of the Program's drug utilization review process. The Board's Drug Utilization Review Committee, along with the epidemiological expertise of the newest Departmental representative on the Board, can assist the Administrator in building a new drug utilization review framework based on internationally established evidence and validated indicators. The review is expected to be complete in 2013 with implementation in 2014. The Department will monitor progress toward completion of this initiative.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation. As with Recommendation #9, the Board will direct the Administrator to include, as part of the updated drug utilization review framework/process noted in the response to Recommendation #8, a quality assurance process to review the adequacy and appropriateness of the work completed by staff on the drug utilization review process, with implementation in 2014.

5.54 *Enforcement processes* – The Program may send letters to prescribers following the review of a drug utilization report. Prescribers are required to provide a response. The Program's medical consultant may also contact prescribers to discuss the specifics of a situation or may request additional information. If the prescriber does not reply before the deadline, a second letter is sent. If a response is still not provided, a final letter is sent indicating the matter will be referred to the College of Physicians and Surgeons of Nova Scotia if a reply is not received.

5.55 We tested 24 initial letters to prescribers and identified three instances in which the file was closed even though the prescriber failed to respond to letters from the Program. While additional evidence may dictate a case can be closed, it is important the Program require all prescribers to respond to its requests for information. The Program should also document decisions made in these cases.

5.56 We also found three situations in which a final letter was not sent in a timely manner.

- Two letters were sent between 19 and 22 days after the deadline in the second letter had passed.
- In one instance, the Program received a response 19 days after the deadline provided on the second letter. A third letter had not been sent, although one should have been triggered as soon as the deadline in the second letter expired.

5.57 If prescribers do not respond to the final letter from the Program there is the option of referring the matter to the College of Physicians and Surgeons of Nova Scotia. However, flexibility is needed to account for situations in which prescribers are not able to provide a response by the established deadline for legitimate reasons.

5.58 *Timeliness of medical consultant review* – The sample we selected from drug utilization review reports included three cases which were referred to the medical consultant for review. While all three situations were reviewed, there is no evidence of when the review was actually completed. The review results were entered in the Program's system between 44 and 92 days after the initial referral to the medical consultant. The contract with the medical consultant establishes review timeframes of between seven and 30 days, although Program management told us these deadlines are not used in practice. Timely review by the medical consultant is important to address potentially inappropriate prescribing practices and prevent misuse or abuse of monitored drugs from continuing for longer than necessary.

Recommendation 5.11
The Nova Scotia Prescription Monitoring Program should implement standard timeframes within which cases referred to the medical consultant should be reviewed. Referrals should be monitored to verify these timeframes are met.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to develop a policy that identifies standard timeframes, based on criticality of cases, within which cases referred to the medical consultant should be reviewed. The policy will be complete in 2013 and implemented as soon after as possible. The Department will follow up with the Board in 2013 to ensure compliance.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to develop, for Board approval, a policy outlining expected review timelines for cases forwarded to the Program's medical consultant. This policy will be based upon the appropriate prioritization of the cases in recognition of the part-time status of the medical consultant. The policy will be developed and implemented in 2013.

5.59 *Complaints* – The Program receives complaints regarding potential abuse or misuse of monitored drugs from a variety of sources including the public, pharmacists, physicians and law enforcement. We reviewed a sample of 21 complaints and found all were addressed in accordance with Program policies. However, we were unable to determine if seven of these complaints were addressed in a timely manner as the completion date was not documented. The remaining 14 complaints were dealt with in a timely manner.

5.60 *Practice Review Committee* – Fourteen prescribers were referred to the Practice Review Committee during our audit period. This Committee provides peer review

of prescriber responses to the Program. We found the Committee took timely and appropriate action in all cases. The Practice Review Committee subsequently referred three of these prescribers to the College of Physicians and Surgeons of Nova Scotia. We note the Program found that the prescribing practices of each decreased subsequent to the referral to the College, suggesting this was a deterrent to inappropriate prescribing

5.61 *Monitoring of methadone programs* – Methadone patients cannot take most other monitored drugs for safety reasons. The Program uses weekly reports to identify any patients in publicly-funded methadone programs who have received monitored drugs, other than methadone. The reports do not identify methadone prescriptions. This is a gap in the Program since a patient could obtain additional methadone from another prescriber and this would not be detected by these weekly reports.

Recommendation 5.12
The Nova Scotia Prescription Monitoring Program's reviews of publicly-funded methadone treatment should identify all prescriptions for monitored drugs, including methadone.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to require the Administrator to include methadone in its regular review of publicly-funded methadone treatment programs by the end of 2012. The Department will follow up with the Board in early 2013 to ensure compliance.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to undertake the changes needed to include all monitored drugs in its review of publicly-funded methadone treatment by the end of 2012.

5.62 We also found that weekly reports were not run for 21 months for the clients of one publicly-funded methadone program. The program name was entered into the information system incorrectly. Instead of providing an error message that the program name was not found, the system returned a message that there were no prescriptions of other monitored drugs for these clients.

Recommendation 5.13
The Nova Scotia Prescription Monitoring Program should change the error messages that occur when a program name entered to generate a report is not found to clearly state that fact, rather than simply returning no data.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to require the Administrator to address the system rule that currently returns no data, rather than an error message, when a program name

entered to generate a report is not found. The Department will follow up with the Board to ensure the system rule is addressed by 2013.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to take the necessary steps by the end of 2012 to ensure that when a program name entered to generate a report is not found, the error message will clearly state that fact.

5.63 *Physician-patient agreements* – In certain situations, physicians may require patients with monitored drug prescriptions to sign an agreement stating they will only receive monitored drugs from that prescriber. The Program maintains a record of these agreements and runs weekly reports on these patients. The reports are reviewed to identify monitored drugs which were prescribed by physicians not covered by the agreement and a letter is sent to the prescriber.

5.64 Both the methadone and patient agreement reports require Program staff to manually review the reports and identify inappropriate prescriptions. If the Program's automated reports were tailored to only identify the problem prescriptions, this manual review would not be necessary. This would reduce the workload of Program staff, as well as eliminate the possibility of human error in reviewing these reports each week.

5.65 We selected a sample of 30 weekly methadone monitoring reports and 30 patient agreement reports. We tested one patient from each report whom we had identified as either having received monitored drugs while taking methadone, or as receiving drugs from another physician after agreeing not to. We found the Program failed to take appropriate action in six of the 60 cases we reviewed; in these instances the prescribers were not informed that their patients had received monitored drugs from another prescriber or pharmacist. Program staff need to ensure letters are sent when required. Recommendation 5.10 in this Chapter notes the need for a quality assurance process to check staff work; implementing this recommendation will also help address this issue.

Recommendation 5.14
The Nova Scotia Prescription Monitoring Program should comply with their policy and send notification letters to all prescribers when instances of patient noncompliance are identified.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to require the Administrator to comply with the policy immediately. The Department will follow up with the Board before the end of 2012 to ensure compliance.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and will direct the Administrator to take the necessary quality assurance steps to ensure continued compliance with its policy. The

steps will include a new method for documenting the activities, which will more clearly demonstrate compliance with the policy. This will be implemented by the end of 2012.

Duplicate Prescription Pads

Conclusions and summary of observations

Prescriptions for monitored drugs must be written on duplicate prescription pads that are only available through the Program. We identified issues with the manner in which prescription numbers could be assigned, but overall, found the security over issuing and storage was adequate. There are policies and procedures in place related to voiding lost, stolen or forged prescriptions, as well as unused prescriptions when a prescriber leaves the Program. However, we found these policies are not always followed. We identified several instances in which prescriptions or pads reported as stolen or forged were not identified as void in the system or were not voided in a timely manner. Furthermore, unused prescriptions of prescribers who left the Program were also either not voided or not voided promptly.

5.66 *Issuing duplicate prescription pads* – Prescriptions for monitored drugs must be written on duplicate prescription pads, which are only issued to prescribers registered with the Program. When prescribers order duplicate prescription pads these are printed the following day and sent via courier. The inventory of templates and assembled pads are kept in a secure room which can only be accessed by a limited number of Medavie (the Program's contracted administrator) employees. A small inventory of blank prescription pads is also kept in another secure location that only Program staff can access.

5.67 In certain situations, internal prescription pad numbers are generated in the system, effectively creating a prescription number without a corresponding physical prescription. The main reason for this occurs when a pharmacy contacts the Program because prescriptions for two monitored drugs were written on one prescription form. Prescription Monitoring Regulations only allow one monitored drug per prescription. The Program generates a prescription number so the pharmacist can have a valid number for each prescription. However, staff do not confirm with the original prescriber that both prescriptions are valid unless this becomes a regular occurrence.

5.68 The Program has policies for issuing and tracking duplicate prescription pads. We tested a sample of 40 prescribers who prescribed monitored drugs during our audit period and found all were registered with the Program when the prescriptions were issued.

5.69 *Voiding duplicate prescription pads* – When duplicate prescription pads are reported lost, stolen or forged, an alert may be sent to pharmacies and the individual prescription numbers are flagged as void in the online system. If a prescription number from a void pad is entered in the online system, the pharmacist receives

a response code notification. However, as discussed earlier, pharmacists can use professional judgement to determine whether to ignore notifications and continue to dispense the medication.

5.70 During our audit period, there were 15 alerts issued for stolen prescription pads containing 225 individual blank prescriptions. Five of these blank prescriptions were not voided and remained active at the time of our audit. Another alert for 23 forged prescriptions included one prescription which was not voided until 11 days after the alert was issued. The remainder were either marked filled, voided, inactive, or stolen prior to or at the time the alert was issued. Failure to promptly cancel known stolen and forged prescriptions means those prescriptions could be used to obtain monitored drugs illegally.

Recommendation 5.15
The Nova Scotia Prescription Monitoring Program should establish a process to ensure all prescription pads reported as lost, stolen or forged are cancelled immediately.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. The Department will direct the Board to require the Administrator to develop a process to ensure all prescription pads reported as lost, stolen or forged are cancelled immediately. The Department will follow up with the Board to ensure this process is in place by the end of 2012.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and notes that this process is already in place. The Board will direct the Administrator to develop and implement a quality assurance process to ensure ongoing compliance with this process by the end of 2012.

5.71 When prescribers retire or leave the Program they are supposed to shred unused duplicate prescription pads. When the Program is notified that a prescriber is leaving, any unused prescription pads issued to that prescriber are to be voided by the Program to prevent improper use. We tested 30 prescribers who left the Program during our audit period and identified 13 with a total of 930 prescriptions which were not voided. Another six prescribers unused prescription pads remained valid until between 11 and 143 days after notification of the prescriber leaving the Program. Since prescribers are not required to return unused prescription pads, canceling these prescription numbers in a timely manner is very important. If these prescription pads are not destroyed by the prescriber, they could be lost or stolen and used to obtain monitored drugs illegally.

5.72 We also found prescribers are not removed from the list of registered prescribers until one year after they give notice of intent to leave the Program. Additionally, these prescribers are allowed to obtain new duplicate pads, although any numbers issued to them are supposed to be automatically marked as void in the system. It is

not clear why the Program would issue duplicate pads and immediately mark them as void. If a prescriber leaves the Program, the individual should be removed from the list of registered prescribers immediately. If notice is given of intent to leave at some future date, prescriptions should remain valid up to that time. Automatically voiding new pads issued means someone who has notified the Program of plans to retire in one month will have current prescriptions marked as void. Depending on the pharmacist dispensing the medication, this may mean patients are not able to fill valid prescriptions for monitored drugs.

Recommendation 5.16
The Nova Scotia Prescription Monitoring Program should not issue duplicate prescription pads to prescribers who are leaving the Program unless these prescribers can demonstrate the need for additional duplicate pads during their remaining time with the Program.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation. When the DIS assumes the prescription capture functions for the Program, the prescription pads will be eliminated. In the meantime, the Department will direct the Board to require the Administrator to confirm processes to address the issue of duplicate prescription pads are implemented by the end of 2012. The Department will follow up with the Board in early 2013 to ensure compliance until the DIS assumes this function.

Nova Scotia Prescription Monitoring Board Response:
The Board agrees with this recommendation and notes that it is current practice. The Board will direct the Administrator to develop and implement a quality assurance process to ensure ongoing compliance with this practice by the end of 2012.

5.73 We recognize that while many of the recommendations made in this Chapter can be easily implemented, others will require support and commitment from all parties involved, including the Department of Health and Wellness, to ensure implementation.

Recommendation 5.17
The Nova Scotia Prescription Monitoring Program, Board, and the Department of Health and Wellness should work together to determine the most efficient and cost-effective means of applying the recommendations in this Chapter.

Department of Health and Wellness Response:
The Department of Health and Wellness agrees with this recommendation and will immediately begin working with the Board to determine the most efficient and cost-effective means of applying the recommendations of this Chapter. The goal is to have acted on all responses by the end of 2014.

Nova Scotia Prescription Monitoring Program Board Response:
The Board agrees with this recommendation and commits to collaborating with the DHW

to determine the most efficient and cost-effective means of applying the recommendations of this Chapter and to act upon the DHW and Board responses by the end of 2014.

Department of Health and Wellness Additional Comments

The Department of Health and Wellness notes the audit recognizes the dual mandate of the Prescription Monitoring Program (encouraging appropriate use and monitoring abuse), but is not in agreement with the Auditor General's assessment that the Program emphasizes its education mandate over its monitoring mandate. The audit scope was not sufficient to make this determination as, " we [the Auditor General] focused our audit largely on the monitoring type activities the Board conducts, as these provided some coverage of all aspects of its mandate."

The Department appreciates the thorough review by the Auditor General on the Prescription Monitoring Program. The Department agrees with all of the recommendations pertaining to the Department and recognizes the importance of monitoring the prescribing and utilization of monitored drugs and appropriate action when potential abuse is identified. Over the next year, the Department will direct the Board on developing and enhancing existing measures for monitoring and evaluating the Board's related compliance.

Office of the Auditor General Comments

The Board has provided additional comments in their response to this Chapter which can be found below.

It is not our practice to attempt to compare Nova Scotia programs with those of other provinces. We are not in a position to verify information available publicly on the internet or elsewhere regarding these programs.

The use of outside expertise was not necessary for this audit.

Nova Scotia Prescription Monitoring Program Board Additional Comments

The Board has confidence in the Program's performance and effectiveness with respect to its legislated mandate to promote the appropriate use of monitored drugs and the reduction of the abuse/misuse of monitored drugs. It recognizes the importance of continuous quality improvement and will collaborate with the DHW to incorporate the recommendations of the Auditor General into the Program's ongoing quality assurance processes.

While the Board agrees with the individual recommendations, it is disappointed with the overall tone of the report and is of the position that it would have benefitted from the report providing comment on whether or not the Program is meeting its mandate. The opportunity existed for the report to acknowledge the existence of a valuable and unique entity of which Nova Scotians should be proud. If that had been the case, the recommendations concerning the need for ongoing Program enhancements and the identification of additional resources to support valuable initiatives would have been a more positive investment in the Program's objectives and its future.

The Board is of the opinion that the audit would have been of even more value to the Board, the Program Administrator and the Nova Scotia public if the Program's performance had been benchmarked against other prescription monitoring programs across the country or industry best practices and further, if the expertise of clinical experts had been utilized during the audit process.

The Board does not agree with the report's suggestion that the Board appears to emphasize education over active monitoring. The Board agrees that its work in the area of education is critical to achieving the Program's legislated mandate of promoting the appropriate use of monitored drugs and the reduction of the abuse/misuse of monitored drugs; however these efforts are not being carried out in a manner that is disproportionate or detrimental to its monitoring role.

NOVA SCOTIA

6 Justice: Office of Public Trustee

Summary

The Office of Public Trustee administers the estates of many of its clients, including deceased persons, children and mentally incompetent individuals. The Office of Public Trustee has a comprehensive policy for managing client investments. We found the Office of Public Trustee managed client investments appropriately, using the prudent investor approach outlined in the policy. The Office of Public Trustee also developed a number of policies to provide guidance to staff in making health care decisions for their clients. We recommended improvements to the complaints policy.

We found a significant weakness in the Office of Public Trustee's processes for collecting client assets; individuals assigned to enter a client's home to identify, assess and collect assets and personal papers are not supervised by Office of Public Trustee staff. While the Office of Public Trustee obtains insurance coverage for its clients' assets, this does not address the risk that assets may be taken without detection or be intentionally undervalued and the full selling amount not remitted. In addition, the privacy and confidentiality of client personal papers may be compromised. Although the Office of Public Trustee has begun a risk assessment of its processes for collecting client assets, we recommended staff supervise the initial assessment and collection of client assets.

The Office of Public Trustee's access control to the locked cabinet where client personal property is stored could be improved. While procedures for the initial receipt and recording of personal property following removal from a client's home are strong, inventory count procedures for those assets are poor and we recommended improvements. As well, the Office of Public Trustee does not perform periodic verification of client assets held long-term by third parties or in offsite storage.

The Office of Public Trustee's financial statements provide adequate information to enable users to evaluate its financial operations. However, the current system is inefficient as a financial accounting and reporting system, and there is a risk of inaccuracies in the financial statements. We recommended the Office obtain a recognized and comprehensive financial accounting system. We also found the system for recording health care decisions needs to be upgraded to improve reporting and data integrity.

We recommended all client files, including those managed by the Public Trustee and senior trust officer, be included as part of the yearly file review process. We also recommended the Office establish performance standards for managing client estates and carry out annual performance evaluations on all staff to ensure performance expectations are being met.

NOVA SCOTIA

6 Justice: Office of Public Trustee

Background

6.1 The Office of Public Trustee provides protection of its clients' financial interests through estate administration services. The Office of Public Trustee may also provide informed consent on clients' behalf for health care, placement to a continuing care home or home care services. It may provide one or both of estate administration and health care decision services to its clients.

6.2 The Office of Public Trustee operates through six program areas.

- Mentally incompetent adult services
- Children's trust services
- Deceased estate services
- Health care decision services
- Missing person services
- Legal representation services

6.3 The Office of Public Trustee is funded through the Department of Justice. In 2010-11, the Office of Public Trustee received $7.6 million in revenues and incurred $9.4 million in expenses on behalf of its clients. Operating costs were $2.1 million, offset by fees and interest of $1 million for a net cost to the province of $1.1 million. For 2011-12, the operating budget for the Office of Public Trustee is $2.2 million.

6.4 In 2010-11, the Office of Public Trustee administered $41.6 million in cash and investments and $9.5 million in real estate and other assets. It opened 281 new client files and closed out 260 files, resulting in 989 active estates and trust files at year end. Adult clients made up the largest group (369), followed by children (200) and deceased estates (180).

6.5 In 2009, the Health Care Decisions Division was established to manage the additional responsibilities of the Office of Public Trustee under the Personal Directives Act. This Act was proclaimed on April 1, 2010; it expanded the authority of the Public Trustee to act as the health care decision-maker of last resort for persons incapable of making those decisions. In 2010-11, the Division served 116 health care clients, including opening 94 new client files and closing 15 files. The Division made a total of 435 health care decisions on behalf of its clients.

6.6 Five trust officers and three lawyers assist the Public Trustee in managing client estates. Two consultants and a coordinator assist with health care decisions. 13 financial and administrative staff carry out other duties and responsibilities.

6.7 As specified in the Public Trustee Act, our Office audits the annual financial statements of the Public Trustee's trust funds.

Audit Objectives and Scope

6.8 In early 2012, we completed a performance audit of the Office of Public Trustee. The engagement was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

6.9 The purpose of our audit was to determine whether the Office of Public Trustee is acting in the best interests of its vulnerable clients.

6.10 The objectives of our audit were to determine whether:

- the Office of Public Trustee appropriately safeguards and manages the opening and closing of client estates;
- the Office of Public Trustee appropriately safeguards and manages client investments and other assets;
- the Office of Public Trustee's processes for making health care decisions on behalf of its clients are appropriate and in accordance with legislation and policies; and
- the Office of Public Trustee's trust funds financial statements are complete and provide appropriate information to users.

6.11 Criteria were developed specifically for this engagement. The objectives and criteria were discussed with, and accepted as appropriate by the Public Trustee.

6.12 Our audit examined the Office of Public Trustee's processes and transactions for the period from April 1, 2010 to September 30, 2011. Our approach consisted of interviews with management and staff; documentation of systems and processes, policies and procedures; and testing and analysis of files and records.

Significant Audit Observations

Opening and Closing Client Estates

Conclusions and summary of observations

The Office of Public Trustee has a number of policies and processes for safeguarding and managing the opening and closing of client estates; we recommended certain policies be updated and strengthened. We found the Office of Public Trustee has not adequately addressed an area of significant risk; auctioneers or other individuals assigned to identify, assess and collect assets from a client's home are not supervised by the Office of Public Trustee. We recommended staff supervise these activities. The Office of Public Trustee has taken steps to carry out a risk assessment of its procedures in collecting client assets, with expected completion in May 2012. We believe all client files, including those managed by the Public Trustee and senior trust officer, should be included as part of the yearly file review process. The Office of Public Trustee has not established performance standards for staff and does not carry out annual performance evaluations for all staff.

6.13 *Safeguarding clients' assets* – When the Office of Public Trustee takes on the management of a client's estate, its responsibilities include identifying, collecting, accounting for and maintaining the client's assets. The Office of Public Trustee has policies on inventorying and safeguarding clients' assets to provide guidance to staff. Staff indicated the policies provide sufficient guidance.

6.14 Although there are a number of policies to address risks to clients' assets, one area of significant risk is not adequately addressed. The Office of Public Trustee hires auctioneers to enter a client's home to collect personal papers, assess the value of assets and collect and sell the assets, as directed. The Office of Public Trustee provides auctioneers with a letter of instruction that outlines their duties and responsibilities. The auctioneers are not required to sign a contract or indicate their acceptance of the terms. If a client does not have sufficient funds to cover the costs of hiring an auctioneer, the Office of Public Trustee will seek assistance from family members or third parties to collect the assets and personal papers.

6.15 Auctioneers or other individuals entering a client's home are not supervised by Office of Public Trustee staff. Although the Office of Public Trustee immediately obtains insurance coverage for the assets of any new clients, this coverage is only effective for known assets that are subsequently stolen or damaged. It does not address the risks when the specific assets in a client's estate are not known. We believe without direct supervision by staff when client assets are initially identified, assessed and collected, the risk of assets being lost, stolen or improperly handled is increased. We noted three risks in particular.

- Individuals sent to pick up assets from a client's home may note an asset was not in the home when in fact it was, and not turn it over to the Office of Public Trustee.

- Individuals assessing the assets may intentionally undervalue them and not remit the full proceeds from their sale to the Office of Public Trustee.
- The privacy and confidentiality of client personal information may be compromised.

6.16 The Office of Public Trustee's research into the practices of the other public trustee offices in Canada shows 10 of the 11 offices require two people, including at least one staff member, to carry out the initial inspection of a client's home.

Recommendation 6.1
The Office of Public Trustee should assign staff to supervise the initial identification, assessment and collection of client assets to ensure all assets are properly accounted for and collected.

Office of Public Trustee Response:
The Public Trustee is in agreement with this recommendation. The Public Trustee does not have inspectors on staff. The Public Trustee's clients live in every corner of this province and the initial inspection could take a day to several days to complete. The Public Trustee has tried to compensate by carefully choosing different reliable individuals to conduct the initial inspections.

In conjunction with Justice Finance, the Public Trustee will co-ordinate and prepare an analysis of the resources required to meet this recommendation. Once this analysis is complete, options are identified, and associated costs are estimated, the Public Trustee will work with Justice Finance to identify the mechanism to fund a solution to this recommendation by March 31, 2014.

In the interim the Public Trustee will develop a letter of instruction that will outline the duties and responsibilities of the auctioneers, caretakers, appraisers or client's family members who are sent into the client's homes searching for assets. The individuals retained to perform these searches will be requested to sign their acceptance of the terms of the direction letter.

The Public Trustee has ordered a risk assessment report of its procedures in collecting and selling clients' assets. This report is scheduled to be completed in May 2012. This report will be carefully reviewed to determine what risks the Internal Auditors have identified. The Public Trustee will then review its existing policies concerning the protection and identification of clients' assets and it will develop new policies and revise existing policies where required to try and mitigate these risks.

6.17 During our audit of the 2010-11 financial statements, we raised our concern that individuals hired to collect client assets were not bonded. The Public Trustee subsequently informed us while there is a lack of bonded individuals performing the needed services, the auctioneers hired carry their own insurance coverage for any

assets they take into their possession. We found the Office of Public Trustee does not verify auctioneers have sufficient insurance coverage.

Recommendation 6.2
The Office of Public Trustee should verify auctioneers have sufficient insurance coverage to protect client assets prior to authorizing the auctioneers to take the assets into their possession for sale.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee will seek written confirmation from its auctioneers that the auctioneer has sufficient insurance coverage to protect the client's assets before the auctioneer is authorized to take the client's assets into their possession.

6.18 In our 2010-11 letter to management, we recommended the Office of Public Trustee perform an assessment of the risks associated with transferring assets from clients' homes and indicate what procedures would be put in place to mitigate the risks identified. We found the Office of Public Trustee has initiated steps to conduct a risk assessment, with expected completion by May 2012.

6.19 We found instances in which policies on inventorying, collecting and safeguarding client assets could be improved or strengthened.

- The policy on initial assessment of personal or real property owned by a client addresses what to do with various client assets, such as items gifted in a will, jewelry and personal papers. The policy does not expressly state that staff should consider the location of, and risks to, all real and personal property, and ensure that the risks have been addressed in a timely manner.
- The purpose of the policy on inspection of client property is to obtain preliminary information about the state of the property. It does not expressly direct staff to consider potentially valuable assets that may be identified by the auctioneer or other individuals during the initial inspection, and how they will be safeguarded.
- The policy on taking possession and disposing of clients' firearms is dated from 1993 and was not filed with the policy manuals. This policy needs to be reviewed, updated and filed in the policy manual to be readily available to all staff.

Recommendation 6.3
The Office of Public Trustee should review its policies on real and personal property to include a general direction to staff to consider and address risks to all property.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee will review its existing policies on real and personal property. The Public Trustee will also review the

recommendations of the risk assessment report currently being prepared to ensure the policies are updated and strengthened to address risks to our clients' real and personal property.

6.20 Staff review client asset and insurance listings twice a year to identify assets that require coverage or those that may no longer need coverage.

6.21 We examined 30 client files to determine if staff are following policies and safeguarding assets when opening and closing client estates. We found one minor instance in which policy was not followed but this was covered through a compensating procedure.

6.22 *Supervision and reviews* – Supervising staff in opening and closing estates and safeguarding clients' assets is an important part of managing operations. Failure to appropriately supervise staff could result in improper or inconsistent handling of estates or untimely completion of required actions, which could put clients' estates at risk.

6.23 One way management can supervise and determine how staff meet their assigned responsibilities and follow policies is through file reviews. The senior trust officer is responsible for completing periodic reviews of files managed by the trust officers. The senior trust officer follows review procedures set out in a file review form and notes issues or provides feedback on the file to the trust officer.

6.24 The Public Trustee completes periodic reviews of files managed by staff lawyers, examining processes used for closing the files, required court filings and other communications. The Public Trustee does not follow specific procedures when completing these reviews but notes questions or comments for staff. A checklist of items to consider would help ensure all relevant areas were covered and consistently reviewed.

Recommendation 6.4
The Office of Public Trustee should develop a checklist or document procedures as a guide for the review of files managed by staff lawyers.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee will develop a set of standard procedures to be used for reviewing files managed by staff lawyers. These standards will be developed by April 1, 2013.

6.25 Client files managed by the Public Trustee and those of the senior trust officer are not included in the periodic file review process. While their files may be reviewed through filings in court or at other times, these reviews are not part of an ongoing quality control process designed to ensure consistency and compliance with Office of Public Trustee policies.

Recommendation 6.5
The Office of Public Trustee should include client files managed by the Public Trustee and those of the senior trust officer as part of the yearly file review process to ensure consistency and compliance with policies.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The files of the Senior Trust Officer will be reviewed as part of this position's annual performance review. The Public Trustee will establish a peer review process for the review of client files managed by the Public Trustee. The peer review will be conducted by one of the Acting Public Trustees and the process will be established by April 1, 2014.

6.26 *Performance evaluations* – Management does not complete a written annual performance evaluation of all staff. While management may meet to discuss performance with staff who have reached the top of their salary range, this process is not always documented and may not be consistent among those staff or cover all areas of performance. Of the eight trust officers and lawyers employed at the Office of Public Trustee during our audit, four received an annual performance evaluation while four did not. Without regular performance evaluations, performance issues with staff may not be appropriately documented and addressed in a timely manner.

Recommendation 6.6
The Office of Public Trustee should complete annual performance evaluations for all staff.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. Informal performance evaluations and review of staff work had been conducted by the Public Trustee and its managers throughout the years. Commencing with the fiscal period April 1, 2012 - March 31, 2013 formal performance reviews will be conducted on all employees.

6.27 The Probate Act and regulations include timelines and specific requirements which the Office of Public Trustee must meet when closing out estates of deceased clients. For other clients, the Office of Public Trustee has not established performance standards for opening or closing files, timing of disbursements and distributions, and securing of physical assets. Establishing performance standards would provide specific guidance to staff on managing their files and would provide a means for the Public Trustee to evaluate operations and determine if staff are meeting performance expectations.

Recommendation 6.7
The Office of Public Trustee should establish and monitor performance standards to ensure staff are meeting performance expectations.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee will analyse the different functions and work the office undertakes, and will determine performance standards for these responsibilities. These standards will be established by March 31, 2014.

Management of Client Investments and Other Assets

Conclusions and summary of observations

The Office of Public Trustee has a comprehensive investment policy that outlines the prudent investor approach and client factors to consider, and appropriately provides guidance on types of investments to purchase. We found the Office of Public Trustee administered client investments in accordance with policy. We found control over access to the locked cabinet where client personal property is stored could be improved, and inventory count procedures for assets held in the vault are poor. We also found the Office of Public Trustee does not perform periodic verification of client assets held long-term in offsite storage.

6.28 *Managing investments* – The Office of Public Trustee's estate management responsibilities include management of client investments. In making investment decisions, the Office of Public Trustee uses a conservative investment approach based on the prudent investor standard. The prudent investor standard is outlined in the Office's investment policy as:

- minimize any risk of loss of capital;
- where possible, provide income sufficient to meet clients' needs; and
- assess the potential for capital appreciation for clients with higher risk tolerances or long-term investment horizons.

6.29 The investment policy outlines the necessity of an investment plan for clients and provides guidance on investment vehicles, minimum ratings for securities and maximum limits on purchases and types of investments. In addition, circumstances specific to each client should be considered, including:

- the client's age, medical prognosis and budget;
- the client's ongoing income needs and ability to accumulate income;
- the requirement for long-term capital appreciation; and
- the expected timeframe of the Office of Public Trustee's authority (investment horizon).

6.30 Nineteen of 30 client files we selected included investments. We examined those files to determine if the client investments were managed appropriately and policies

were followed. We found investments were administered using a prudent investor approach in accordance with policy.

6.31 *Managing other assets* – Estate administration may involve determining client spending allowances and expense requirements, and setting up payments to meet those requirements. It may also involve safeguarding and managing other assets, such as real estate or personal property. The Office of Public Trustee has a number of policies to assist staff in those areas of administration.

6.32 Our testing of 30 client files included determining if estate administration procedures were appropriate and policies were followed. We found policies were followed in administering client estates. However, we found significant weaknesses in the Office of Public Trustee's procedures for safeguarding personal property.

6.33 *Safeguarding personal property* – Office of Public Trustee clients may have personal property, such as jewelry or coin collections, that are valuable and need to be safeguarded. When personal property is small in size, the Office of Public Trustee may secure and store it in the office vault until returned to the client, sold or distributed. While procedures for receiving and recording client assets following removal from a client's home are strong, all accounting staff can access the vault and the locked storage cabinet in the vault where assets are stored. All accounting staff can access the listing of assets held in the vault and can add and remove items.

6.34 To reduce the risk of small, valuable items being lost or stolen, access to the locked storage cabinet in the vault should be restricted. Management should have control of the keys, and a sign-out process should be established to track access to the secure storage area.

Recommendation 6.8
The Office of Public Trustee should restrict and track staff access to the secure storage cabinet in the vault.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee will develop a procedure that will require access to the locked cabinet to be tracked. Two authorized staff members will need to be present when the locked cabinet is opened. This procedure will be completed by October 31, 2012.

6.35 The Office of Public Trustee indicated inventory counts of client assets held in the vault are not carried out on a regular basis; accounting staff carry out inventory counts when time permits and staff are available. When an inventory count is completed, it is performed by one person and the count records are not retained. Without appropriate documentation, we cannot be sure these counts are taking place or how often. When we tested the vault listing and assets in the vault, we found no errors and client ownership was clearly identified for assets held.

6.36 To be an effective control, inventory counts should be carried out on a regular basis by two persons. Management should review and retain count documentation. For additional security, one of the individuals assisting with the count should not have access to client records.

Recommendation 6.9
The Office of Public Trustee should carry out inventory counts on the assets stored in the vault on a regular basis. Management should review and retain inventory count records.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee has already developed a formalized procedure to ensure that audits are performed annually and that documentation of the count is maintained.

Recommendation 6.10
The Office of Public Trustee should have two persons carry out the inventory counts. This should preferably include someone who does not have access to client records.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee has already developed a formalized procedure that will require audits of the other assets in the vault to be performed annually by two staff.

6.37 Valuable client assets may also be stored by auctioneers, other individuals, in offsite storage facilities, or on a client's property until the assets are sold, returned to the client or distributed to heirs and beneficiaries. In certain situations, the Office of Public Trustee obtains a signed agreement that an individual is holding assets in trust for the client's estate. For assets held long-term, staff do not periodically complete an inventory count to ensure all items remain safely stored. Without periodic verification of items in storage, assets may be lost or stolen and the loss may not be detected in a timely manner.

Recommendation 6.11
The Office of Public Trustee should carry out periodic verification of client assets held long-term in offsite storage.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. It will develop a policy detailing how staff is to periodically verify the existence and condition of the client's assets held in long term storage.

6.38 *Improvements to policy* – The Office of Public Trustee has a policy that requires staff to obtain a monthly financial summary report of clients' cash balances and use this

report to determine if there are excess funds which should be invested. We found evidence in the files that the financial summary reports were being generated but we could not determine whether the reviews had been carried out each month as required. A tracking log or other mechanism would provide evidence that staff is performing monthly reviews.

Recommendation 6.12
Office of Public Trustee staff should include evidence in client files that client financial summary reports are reviewed monthly.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee has already developed a tracking log to be completed on a monthly basis which will provide evidence that the client summary reports are being reviewed monthly.

Health Care Decisions

Conclusions and summary of observations

The Office of Public Trustee has a number of policies to provide appropriate guidance to staff in making health care decisions on behalf of its clients. Staff plan to review and update policies on a regular basis. The Health Care Decisions Division could improve its complaints policy to include logging and tracking complaints it receives. The Division is developing a file review process which will enable it to determine whether policies and documentation best practices are followed. The Office of Public Trustee needs to upgrade the information system to improve management reporting and data integrity.

6.39 *Authority* – The Office of Public Trustee's authority to make health care decisions on behalf of its clients is contained in several pieces of legislation and is reflected in the referral process of the Health Care Decisions Division (Division). When seeking the Public Trustee's consent on a health care matter, the health care provider must submit a referral form and supporting documents that show the client lacks the capacity to make the decision and there is no higher-ranked substitute decision maker available, such as a family member.

6.40 The Division has a number of policies that provide assistance and guidance to staff in making health care decisions on behalf of its clients. Staff developed these policies based on legislation, research and ongoing experience gained in making health care decisions. Staff plan to review and update policies on a regular basis.

6.41 *Making health care decisions* – Staff are aware of the Division's policies and procedures and use them when making health care decisions for clients. We selected a sample of 30 health care decisions involving 25 clients to determine if the decisions were appropriately supported and policies followed. We found support in the client

files for the decisions made and that policies were followed. Although there were no serious deficiencies, we found three cases in which documentation could be improved to support the decisions made.

- Follow-up on an outstanding question concerning a client's family was not documented.
- The wrong form was used to document a client's lack of capacity to consent to treatment.
- The need for a routine diagnostic test for a client was not clearly detailed in the notes and forms in the file.

6.42 The Division is in the process of developing file review procedures which will involve an annual cycle of file reviews for compliance with policies and statutory requirements. This will enable the Division to detect and correct documentation deficiencies and establish documentation best practices.

6.43 *Complaints* – There is a complaints policy and process which is adequate for the current size and activity level of the Division. Since the Division expects the number of clients and health care decisions to continue to increase, the policy could be strengthened. We noted the following weaknesses in the existing policy.

- There is no guidance on when staff should request complainants to document their complaints in writing to avoid any misunderstanding regarding the nature of the complaint.
- Staff document complaints in individual client files but there is no single list or tracking of complaints for management to know how many complaints were received and when they were resolved.

6.44 The Division indicated there was only one complaint received during our audit period and we found it was appropriately resolved.

Recommendation 6.13
The Office of Public Trustee should update the health care decisions complaints policy to include guidance on when to request a complaint be submitted in writing.

Office of Public Trustee Response:
The Public Trustee agrees that the complaints policy should be strengthened and has already revised the policy, as recommended.

Recommendation 6.14
The Office of Public Trustee should log and track complaints received to ensure timely disposition.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The revised complaint policy (see response to Recommendation 6.13) now requires that a divisional complaint log be maintained.

6.45 *Oversight and reporting* – Management oversight and review is generally not documented due to the small size of the Division. Management discusses and communicates daily with staff and has initiated a few file reviews. The Division is developing an annual file review process which management expects to implement in 2012.

6.46 Management prepares monthly reports on the Division's activities for the Public Trustee. The monthly reports include a number of statistics, such as the number of opened and closed files, referrals and types of referrals. Management and the Public Trustee use this information to monitor and determine demand on resources and for future planning.

6.47 *Information system* – When the Division was created in 2009, staff needed to capture health care information on clients and record decisions made. The Office of Public Trustee hired a consultant to make modifications to the existing information system. Additional system adjustments were subsequently obtained through the Department of Justice's IT services. The modifications and adjustments provide staff the means to record activities and decisions on an individual client but do not provide adequate reporting for management purposes.

6.48 Due to budget constraints, when the initial modifications were made to the information system, the ability to generate reports from the data captured was not addressed. The system could provide detailed information on each client but a summary report could not be obtained. Management had to capture this information manually. In July 2011, after further adjustments, the system was able to produce a report on client activity. While this report captures some of the information required by management, it still does not provide all that is needed. Management must still manually track certain information, such as types of decisions made and summary totals, in order to monitor and report on the Division's activities and use of resources.

6.49 In addition to reporting difficulties, the information system lacks flexibility to accommodate the Division's needs. One example we noted concerned changes in health care decision authorizations. Authorizations are programmed into the system, preventing staff with a lower authorization from recording health care decisions requiring a higher authorization. If a health care decision is subsequently determined by management to require a higher level of authorization, the change cannot be adjusted directly in the system without affecting previous decisions recorded. Changing the authorization level directly will show any previous decisions at the new authorization level and remove from the record the name of any staff with a lower authorization who recorded the decision. This does not occur if the authorization is changed from a higher level to a lower level. While this does not affect the client and

the actual decision made, it can impact the integrity of the data management uses for monitoring and reporting purposes.

Recommendation 6.15
The Office of Public Trustee should obtain sufficient IT services to upgrade the current information system to meet the needs of the Health Care Decisions Division.

Office of Public Trustee Response:
The Public Trustee agrees with this recommendation. The Public Trustee has already contacted Justice I.T. to review the observations and recommendations. An analysis of the required upgrades, costs, and implementation plan for information system enhancements will be completed by March 31, 2013. Once associated costs are estimated, the Public Trustee will work with Justice Finance to identify the mechanism to fund a solution to this recommendation.

Financial Statement Presentation and Disclosure

Conclusions and summary of observations

The Office of Public Trustee's trust funds financial statements provide adequate information to enable users to evaluate the Office's financial results. However, the system currently used to record financial transactions is inefficient as a financial accounting and reporting system. There is a risk of inaccurate recording in the financial statements. Considerable effort is required each year for the Office of Public Trustee to produce complete and accurate financial statements because there is extensive analysis of recorded transactions to ensure each has been classified properly on the financial statements. We recommended the Office of Public Trustee obtain a recognized and comprehensive financial accounting system.

6.50 *Financial statement information* – Financial statements are an important source of information to enable readers to evaluate the financial stewardship of the Office of Public Trustee. We considered the reporting requirements under the Public Trustee Act and the information needs of the likely users of the financial statements to determine if the Office's financial statements provided sufficient information. We found the financial statements provided sufficient information to evaluate the Office of Public Trustee's financial results. An improvement is that Other Income should be broken down further to provide additional details on the nature of these transactions. In addition, the Statement of Continuity of Assets should provide the gross amount of assets acquired and assets distributed during the year.

6.51 *Financial reporting system* – The system used by the Office of Public Trustee to provide information for managing client assets is the same system used for financial reporting purposes. Assets held are identified by client and listed by description and value. Trust officers use these listings to monitor client activity and to meet client needs, such as ensuring there are adequate funds available on a timely basis for living expenses.

6.52 There are significant deficiencies in the ability of the system to function as a financial reporting system.

- The system cannot produce a trial balance.
- There is no general ledger.
- There are no income statement accounts.
- Since certain assets in an estate may ultimately belong to more than one heir, the value of the asset must be recorded twice for client management purposes, and then tracked to ensure the asset is not double counted.
- Financial statements can only be produced at year end, and only by analyzing the nature of all cash receipts and disbursements each month.
- The system output must be transferred to spreadsheets, analyzed, and updated before producing financial statements.

6.53 In addition, there are two significant risks associated with the current process.

- Only one staff member is familiar enough with the process to translate the system output into financial statements.
- There is increased risk of error in the balances and classifications within the financial statements because of the need to transfer output to a spreadsheet, analyze it, and produce financial statements.

6.54 The existing system was put in place several years ago and the processes outside the system have increased and evolved over time to accommodate the Office of Public Trustee's financial reporting needs. For example, the extent of supporting analysis increased substantially in 2008 when the Office of Public Trustee adopted a new accounting standard requiring fair value measurement. That year was also the first year the Office included an income statement in the financial statements.

6.55 Considerable effort is required each year to produce accurate and complete financial statements for the Office of Public Trustee. The process is inefficient and would not be as cumbersome if the Office was to obtain a financial accounting and reporting system. This system needs to meet an overall objective of financial reporting which is to provide complete and accurate information during the year for decision-making purposes. The Office of Public Trustee needs to obtain a financial accounting and reporting system which is able to produce accurate and complete financial information on a timely basis.

Recommendation 6.16
The Office of Public Trustee should obtain a recognized and comprehensive financial accounting and reporting system.

Office of Public Trustee Response:

The Public Trustee is in agreement with this recommendation. The Public Trustee appreciates the thorough review of and recommendation for the financial system. In conjunction with Justice Finance, I.T. and Internal Audit, the Public Trustee will co-ordinate and prepare an analysis of establishing a recognized and comprehensive financial accounting and reporting system by March 31, 2014. Once this analysis is complete, options are identified, and associated costs are estimated, the Public Trustee will work with Justice Finance to identify the mechanism to fund a solution to this recommendation.

The Public Trustee will review whether Other Income could be further classified into component amounts to provide additional details on the nature of these transactions by March 31, 2013.

Training on some elements of the financial statements has already been provided. Additional training will be provided to ensure that year end accounting could be provided in the absence of the Director of Finance, Administration and Systems.