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.

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1 Message from the Auditor General

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

This report contains five chapters in addition to this introduction. Four of these chapters report the results of our performance audits which were completed in 2011 and early 2012; the remaining chapter includes results from the follow-up of our 2005 to 2009 performance audit recommendations.

Lack of Oversight by the Department of Health and Wellness

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.

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.

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 service standards.

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.

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

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.

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.

2 Follow-up of 2005 to 2009 Performance Audit Recommendations

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.

Recommendations

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

3 Health and Wellness: Addiction Services at Annapolis Valley Health

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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Recommendations

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.

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.

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

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

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

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

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.

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

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

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

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

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

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

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

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.

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Recommendations

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.

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.

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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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.

Recommendation 4.15
Capital Health should finalize its flash sterilization policy.

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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.

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.

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

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.

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

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

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.

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.

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.

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.

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

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.

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

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.

5 Health and Wellness: Nova Scotia Prescription Monitoring Program

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.

Recommendations

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

6 Justice: Office of Public Trustee

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.

Recommendations

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.

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.

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.

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.

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.

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

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

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

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.

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.

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

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

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.

Recommendation 6.14
The Office of Public Trustee should log and track complaints received to ensure timely disposition.

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.

Recommendation 6.16
The Office of Public Trustee should obtain a recognized and comprehensive financial accounting and reporting system.