# AUDITOR GENERAL
## of Newfoundland and Labrador

# Report to the House of Assembly on Performance Audits of Departments and Crown Agencies

## November 2016

# Office of the Auditor General
# Newfoundland and Labrador

The Auditor General reports to the House of Assembly on significant matters which result from the examinations of Government, its departments and agencies of the Crown. The Auditor General is also the independent auditor of the Province's financial statements and the financial statements of many agencies of the Crown and, as such, expresses an opinion as to the fair presentation of their financial statements.

## VISION

*The Office of the Auditor General is an integral component of Government accountability.*


**Head Office Location**

7 Pippy Place
St. John's
Newfoundland and Labrador
Canada
A1B 3X2

**Mailing Address**

P.O. Box 8700
St. John's
Newfoundland and Labrador
Canada
A1B 4J6
**Telephone:** (709) 729-2700
**Email:** oagmail@oag.nl.ca
**Website**: www.ag.gov.nl.ca/ag

**Regional Office Location**

1 Union Street
Corner Brook
Newfoundland and Labrador
Canada

**AUDITOR GENERAL**
**of Newfoundland and Labrador**

November 2016

The Honourable Tom Osborne, M.H.A.
Speaker
House of Assembly

Dear Sir:

In compliance with the *Auditor General Act*, I have the honour to submit, for transmission to the House of Assembly, my Report on Performance Audits of Departments and Crown Agencies for 2016.

Respectfully submitted,

**TERRY PADDON, CPA, CA**
**Auditor General**

7 Pippy Place, PO Box 8700 ♦ St. John's, NL ♦ A1B 4J6 ♦ (709) 729-2700 Email: terrypaddon@oag.nl.ca
1 Union Street, Corner Brook, Box 2006 ♦ Corner Brook, NL ♦ A2H 6J8 ♦ (709) 637-2291

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# CHAPTER 1

# COMMENTS OF THE AUDITOR GENERAL

This is my fifth report, as Auditor General, on Reviews of Departments and Crown Agencies. This report reflects the work of the Office of the Auditor General over the past year focusing on specific programs within Government departments and agencies. A separate report was issued related to the Consolidated Summary Financial Statements for the year ended March 31, 2016.

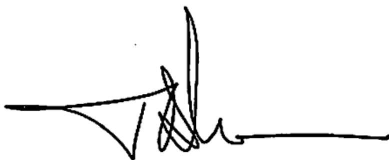
The *Auditor General Act* requires that I report, at least annually, to the House of Assembly on the work of the Office. This report, and the report on the Consolidated Summary Financial Statement of the Province, fulfill the requirements of the *Auditor General Act*.

We plan our work based on a risk assessment of various programs administered by Government departments or through crown agencies. We also receive information and requests from individuals outside our office which we evaluate to determine whether we will undertake work in a particular area. This report provides recommendations resulting from our review of the following 7 different programs and crown agencies:

- Teacher Allocation in Schools
- Child Protection Services
- Acute Care Bed Management
- Road Ambulance Services
- Salaries Physicians
- Fire and Emergency Services - Newfoundland and Labrador
- Safety and Weight Inspections of Commercial Vehicles

The information is provided to Members of the House of Assembly for their consideration. Recommendations contained in this report are intended to strengthen the overall level of accountability within Government and help ensure a greater level of stewardship of public money. I look forward to continued collaboration with the Public Accounts Committee as they consider the recommendations contained in this Report.

I wish to acknowledge the cooperation and assistance that my Office has received from Government departments and agencies during the conduct of our reviews. I also wish to thank the staff of the Office of the Auditor General for their support, dedication and professionalism throughout the year.



**TERRY PADDON, CPA, CA**
**Auditor General**

# CHAPTER
# 2
# OUR OFFICE

The Office of the Auditor General operates from two locations - St. John's and Corner Brook. The staff of the Office contribute, as a team, in the preparation of the November 2016 Report on Reviews of Departments and Crown Agencies.

The following is the staff of the Office of the Auditor General as of October 31, 2016:

Fiona Bai
Snow Bai, CPA, CA
Marc Blake, CPA, CA
Greg Butler, CPA, CMA
Keith Butt, CPA, CA
Ratidzo Chikari
Martin Cook
Allison Corcoran, CPA, CA
Lisa Duffy, CPA, CA
Chris Fudge
Gregg Griffin
Cayla Hillier, CPA, CMA
Jenna Hillyard, CPA, CA
Jeremy Hynes
Travis Ivany
Dianna Kane, CPA, CA
Trena Keats, CPA, CA
Nancy King
Melissa Lewis
Stephanie Lewis, CPA, CA
Ruochen Li, CPA, CMA
Michael MacPhee, CPA, CA
Adam Martin, CPA, CA
Jayme Martin, CPA, CA
Leif Martin, CPA, CA
Trevor McCormick, FCPA, FCGA
Jessica Nugent, CPA, CA
Tracy Pelley, CPA, CMA
Thomas Pritchard, CPA, CA
Pauline Reynolds, CPA, CMA
Sandra Russell, CPA, CA
Walter Scott
Lindy Stanley, CPA, CA
Jessie Tuff, CPA, CA
Scott Walters, FCPA, FCA
Tony Wiseman

# CHAPTER
# 3
# PERFORMANCE AUDITS OF
# DEPARTMENTS AND CROWN AGENCIES

# PART 3.1

# DEPARTMENT OF ADVANCED EDUCATION, SKILLS AND LABOUR

# TEACHER ALLOCATION IN SCHOOLS

# Summary


## Introduction

The Department of Education and Early Childhood Development is responsible for the K-12 school system including the allocation of teachers to the school districts.

The Province has two school districts: the Newfoundland and Labrador English School District and the Conseil Scolaire Francophone Provincial. The school boards administer the daily operations of schools in the Province and the deployment of resources, such as teachers, to individual schools.

Beginning in the 2008-09 school year, the Department of Education and Early Childhood Development began allocating teachers to school districts in accordance with a revised Teacher Allocation Model which was based upon certain recommendations from the May 2007 commissioned report *Education and Our Future: A Road Map to Innovation and Excellence* (the Teacher Allocation Commission Report).

## Objectives

The overall objective of our audit was to determine whether the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District had properly implemented and assessed the Teacher Allocation Model. The objectives of our audit were to determine whether:

1. The Department of Education and Early Childhood Development had goals and measurable objectives for the Teacher Allocation Model.

2. The Department of Education and Early Childhood Development had assessed the outcomes of implementing the Teacher Allocation Model.

3. Teachers were allocated and deployed in accordance with the Teacher Allocation Model and guidance.

## Scope

Our audit covered the school years beginning September 1, 2005 through to September 1, 2015. Our audit included an examination of the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District. Our audit was limited to schools in the Newfoundland and Labrador English School District and did not include schools at the Conseil Scolaire Francophone Provincial.

Our audit included interviews with officials from the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District. We conducted a detailed inspection of documentation maintained by the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District. We also reviewed teacher allocations, deployments and assignments at schools to determine compliance with the Teacher Allocation Model and other relevant guidance. Sample selections were non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

## Importance to Newfoundlanders and Labradorians

In order to ensure the highest quality education for K-12 students in the Province, the Department of Education and Early Childhood Development implemented a revised Teacher Allocation Model so that, despite declining student population, students would continue to be engaged in a high quality curriculum that would prepare them for successful post-secondary education and future career opportunities. The Province spent $515.6 million for teaching services to students in the K-12 education system during the fiscal year ended March 31, 2016. Given this significant investment, it is important that the Teacher Allocation Model remains relevant and that intended outcomes from its implementation are met.

## Conclusions

### Objective 1

The Department of Education and Early Childhood Development did not formally document the goals and objectives for the Teacher Allocation Model. The goals were not linked to intended results and the objectives for the Teacher Allocation Model were not specific, measurable and did not include set time frames.

### Objective 2

The Department of Education and Early Childhood Development has not formally evaluated the Teacher Allocation Model to determine whether the intended results were achieved.

### Objective 3

Teachers were not always allocated and deployed in accordance with the Teacher Allocation Model and guidance.

## Findings

### Goals, Objectives and Evaluation of the Teacher Allocation Model

***Goals of the Teacher Allocation Model***

1. The Department of Education and Early Childhood Development did not establish goals for the revised Teacher Allocation Model, which was provided with approximately $20 million annually to implement, that indicate desired results or the timeframe to achieve those results.

***Objectives of the Teacher Allocation Model***

2. The Department of Education and Early Childhood Development did not establish specific, measurable objectives for the revised Teacher Allocation Model.

***Evaluation of Outcomes of the Teacher Allocation Model***

3. The Department of Education and Early Childhood Development was unable to compare actual outcomes to specific targets because the objectives established were not specific, measureable, or time based.

4. Despite being directed by Cabinet to evaluate the Teacher Allocation Model three years after it was implemented in 2008-09, the Department of Education and Early Childhood Development has not completed the assessment and has not reported back to Cabinet.

5. The Department of Education and Early Childhood Development did not develop an evaluation framework to periodically evaluate the Teacher Allocation Model in order to determine the impact of increasing or decreasing teaching units, whether intended results were achieved and whether changes in the strategy were required.

### Allocation and Deployment of Teachers

***Guidance in Applying the Teacher Allocation Model***

6. The allocation methodology used by the Newfoundland and Labrador English School District was generally in accordance with guidance provided by the Department of Education and Early Childhood Development.

***Allocation and Deployment of Teachers***

7. The Department of Education and Early Childhood Development applied the Teacher Allocation Model for Component 1 teaching units in accordance with its policies and guidance.

8. The Department of Education and Early Childhood Development did not have any documentation to support the allocation decisions for Component 2 teaching units for the 2014-15 school year.

9. The Newfoundland and Labrador English School District did not always deploy Component 1 teachers, such as guidance counsellors and specialists in accordance with the Teacher Allocation Model.

10. The Newfoundland and Labrador English School District was deploying classroom teachers in accordance with the Teacher Allocation Model.

11. The Newfoundland and Labrador English School District did not deploy Component 2 pervasive needs teachers consistently throughout the Province.

12. Schools were assigning teachers in accordance with the Teacher Allocation Model and Newfoundland and Labrador English School District deployment decisions.

***Teacher Deployment Outside of the Teacher Allocation Model***

13. The Department of Education and Early Childhood Development allocated one full teaching unit to Kindergarten even though most schools in the Province only offered Kindergarten for ½ day and required only 0.5 of a teaching unit. As a result, the Department of Education and Early Childhood Development allocation did not accurately reflect the needs of the Newfoundland and Labrador English School District. The Newfoundland and Labrador English School District used the additional units for other grades and categories.

## Recommendations

1. The Department of Education and Early Childhood Development should, with the assistance of the Newfoundland and Labrador English School District, establish a formal evaluation framework that includes documented goals, specific objectives, performance indicators, expected outputs and expected outcomes. The Department of Education and Early Childhood Development should use this framework to periodically evaluate the Teacher Allocation Model to determine whether intended results are being achieved.

2. The Department of Education and Early Childhood Development should determine whether an evaluation of the Teacher Allocation Model as directed by Cabinet is still required.

3. The Department of Education and Early Childhood Development should ensure that the Teacher Allocation Model reflects the teaching needs of Kindergarten classes.

4. The Department of Education and Early Childhood Development should ensure that the deployment for all Component 2 - needs-based teachers is supported, consistently applied amongst all Newfoundland and Labrador English School District regions and based upon the special needs of students each year.

5. The Newfoundland and Labrador English School District should ensure that the deployment of all needs-based teachers is supported and communicated to the Department of Education and Early Childhood Development.

## Importance of implementing these recommendations

If our recommendations are not implemented, it will be difficult for the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District to determine if the Teacher Allocation Model continues to be relevant, and whether the Teacher Allocation Model contributes to the instructional and behavioral needs of students and achieves intended student and learning outcomes.

# Objectives and Scope

## Objectives

The overall objective of our audit was to determine whether the Department of Education and Early Childhood Development (the Department) and the Newfoundland and Labrador English School District (the District) had properly implemented and assessed the Teacher Allocation Model.

The objectives of our audit were to determine whether:

1. The Department had goals and measurable objectives for the Teacher Allocation Model.

2. The Department had assessed the outcomes of implementing the Teacher Allocation Model.

3. Teachers were allocated and deployed in accordance with the Teacher Allocation Model and guidance.

Criteria were developed specifically for this audit based upon relevant legislation, Department and District policies and procedures, our related work, reviews of literature, and discussions with management. The criteria were accepted as suitable by the senior management of the Department and District.

## Scope

Our audit covered the school years beginning September 1, 2005 through to September 1, 2015. Our audit included an examination of the Department and the District. Our audit was limited to schools in the District and did not include schools at the Conseil Scolaire Francophone Provincial (CSFP).

Our audit included interviews with officials from the Department and the District. We conducted a detailed inspection of documentation maintained by the Department and the District. We also reviewed teacher allocations, deployments and assignments at schools to determine compliance with the Teacher Allocation Model and other relevant guidance. Sample selections were non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

# Background

The Department of Education and Early Childhood Development is responsible for the K-12 school system including the allocation of teachers to the school districts.

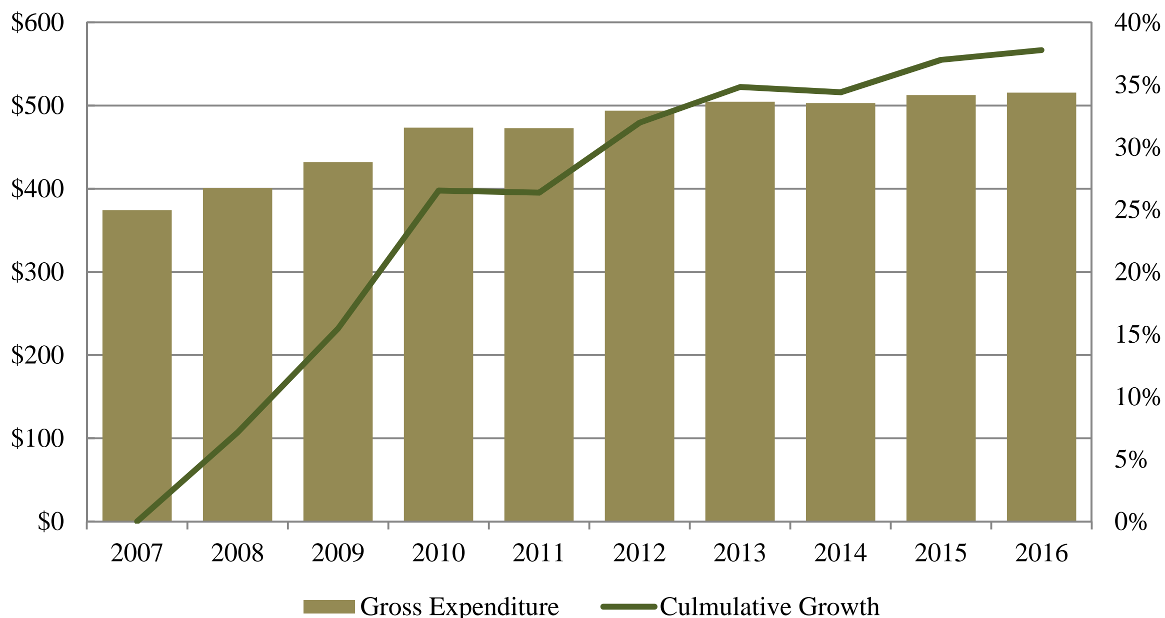
The Province has two school districts: the Newfoundland and Labrador English School District and the Conseil Scolaire Francophone Provincial. The school boards administer the daily operations of schools in the Province and the deployment of resources, such as teachers, to individual schools.

**Teaching Services Expenditures**

Chart 1 shows the Department's expenditures for teaching services from 2007 to 2016.

**Chart 1**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Teaching Services Expenditures**
**Fiscal Years Ended March 31**
**($ Millions)**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Province's Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund.

Teaching services costs increased from $374.2 million for the fiscal year ended March 31, 2007 to $515.6 million for the fiscal year ended March 31, 2016, a cumulative increase of 38%.

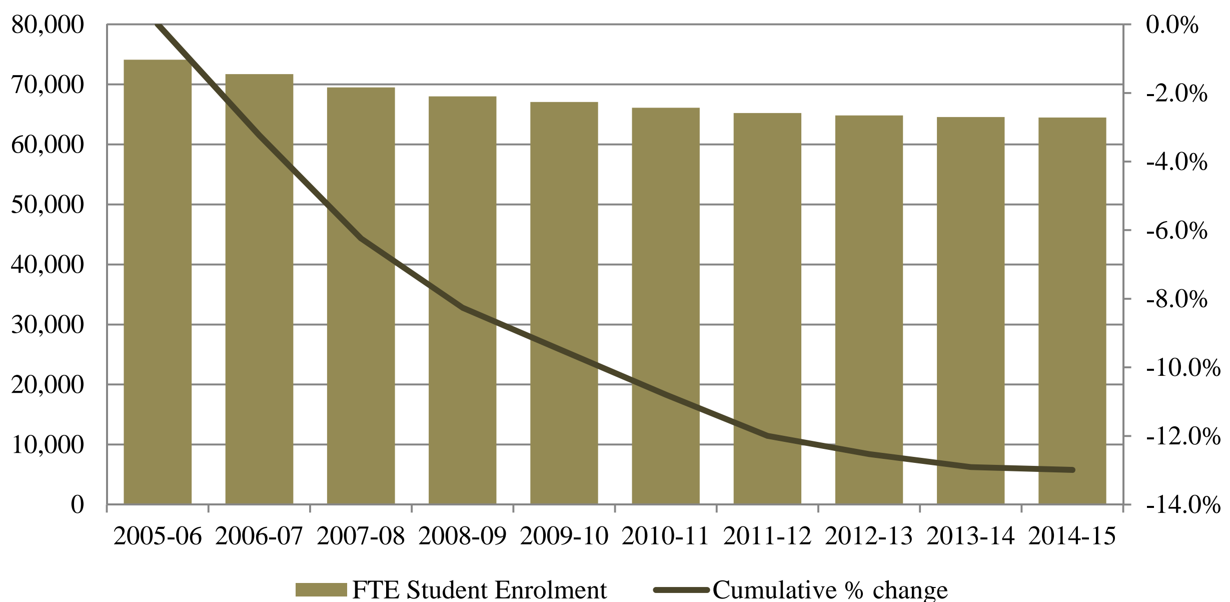
**Student and Teacher Trends**

Each year, the Department reports the number of full-time equivalent students and full-time equivalent teachers. Full-time equivalent students include Kindergarten students who attend school 50% of a school day and are counted as one half. Full-time equivalent teachers include part-time teachers according to the percentage of time they are employed.

Chart 2 shows the number of full-time equivalent students enrolled in the District from 2005-06 to 2014-15.

**Chart 2**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Full-Time Equivalent Students**
**School Years Beginning September 1**



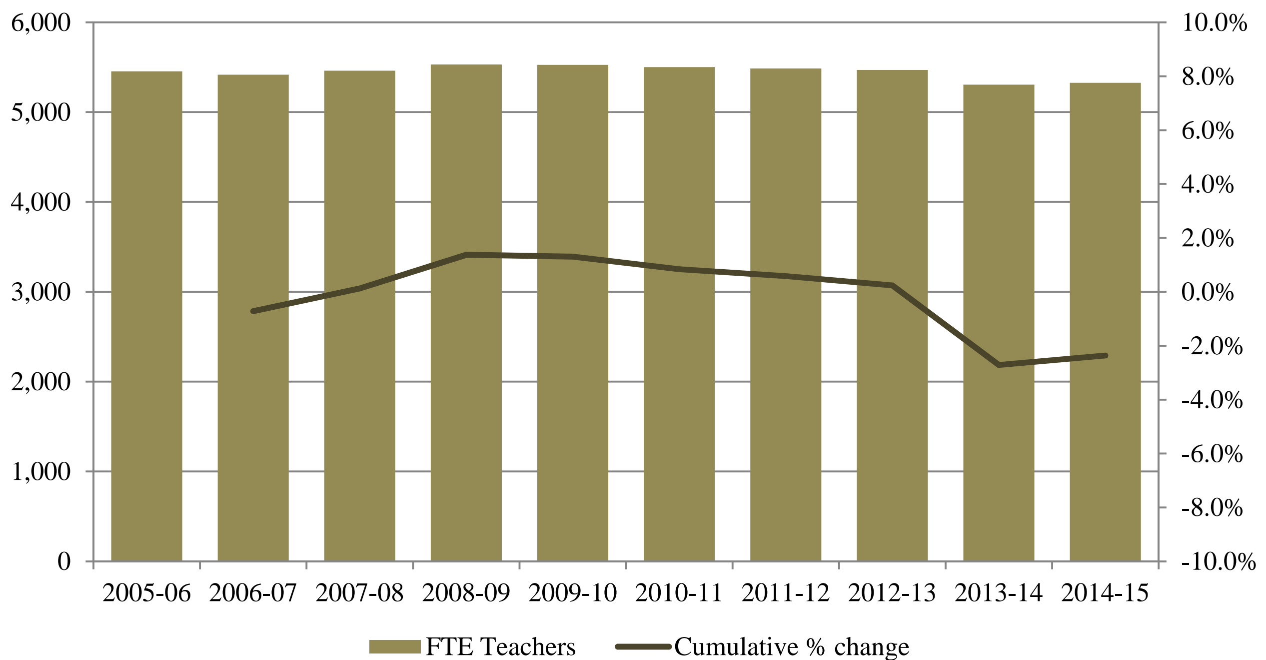

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Education and Early Childhood Development's Education Statistics (unaudited).

The number of full-time equivalent students declined from 74,125 in 2005-06 to 64,495 in 2014-15, a decrease of 9,630 student or 13%.

Chart 3 shows the number of full-time equivalent teachers in the District from 2005-06 to 2014-15.

**Chart 3**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Full-Time Equivalent Teachers**
**School Years Beginning September 1**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Education and Early Childhood Development's Education Statistics (unaudited).

The number of full-time equivalent teachers has declined from 5,456 in 2005-06 to 5,327 in 2014-15, a decline of 129 full-time equivalent teachers or 2.4%.

The pupil-teacher ratio (PTR) during this same period decreased from 13.6 pupils per teacher in the 2005-06 school year to 12.1 pupils per teacher in the 2014-15 school year.

**Teacher Allocation**

In April 2007, the Minister of Education stated that the Province's challenge was to ensure that, despite a declining population, students could engage in a high quality curriculum to prepare them for a successful post-secondary education and future career opportunities. The Minister indicated that the teacher allocation model was being reviewed.

In March 2008, a revised teacher allocation was announced that would change from the traditional numeric formula to a needs-based allocation method resulting in more teachers being maintained in the schools. The revised allocation would include a reduction in maximum class sizes and allow for a greater allocation of specialists, administrators and instructional educational officers.

Beginning in the 2008-09 school year, the Department began allocating teachers to school districts in accordance with the revised Teacher Allocation Model which was based upon recommendations from the May 2007 report *Education and Our Future: A Road Map to Innovation and Excellence* (the Teacher Allocation Commission Report). The terms of reference for the report included Government's commitment to limiting class sizes, increasing high school graduation rates, and the need for the model to meet unexpected and emerging needs.

The revised Teacher Allocation Model, although still based in part on student enrolments, emphasized the allocation of teachers based on the needs of students and also provided class cap sizes for grades K- 9.

Cabinet directed the Department to complete an evaluation of the Teacher Allocation Model at the end of three years after implementation (i.e. after the 2010-11 school year).

**Student Achievement Trends**

The Department and District report a number of student achievement statistics as an indication of how well students are performing in the Province over time and in comparison to other Provinces.

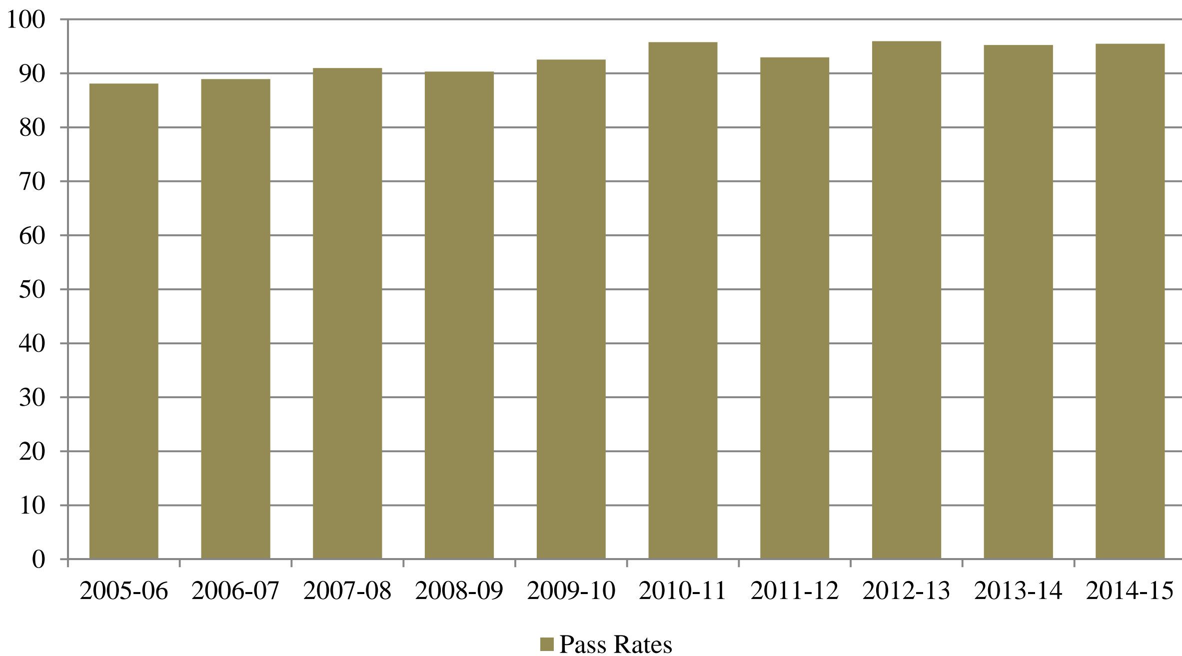
*High school pass rates*

The Department determines high school pass rates based upon the percentage of eligible number of students who can write public exams in a particular year compared to those that pass. Eligible students are students that have a minimum of 22 credits and are attempting sufficient and appropriate credits to graduate.

Chart 4 provides a nine-year trend of high school pass rates within the Province.

**Chart 4**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**High School Pass Rates**
**School Years Beginning September 1**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department's Education Statistics (unaudited).

The pass rate reported by the Department has increased from a pass rate of 88% in the 2005-06 school year to 95% in the 2014-15 school year. However, the Department's calculation of the high school pass rate does not include students who drop out or otherwise leave the high school system.

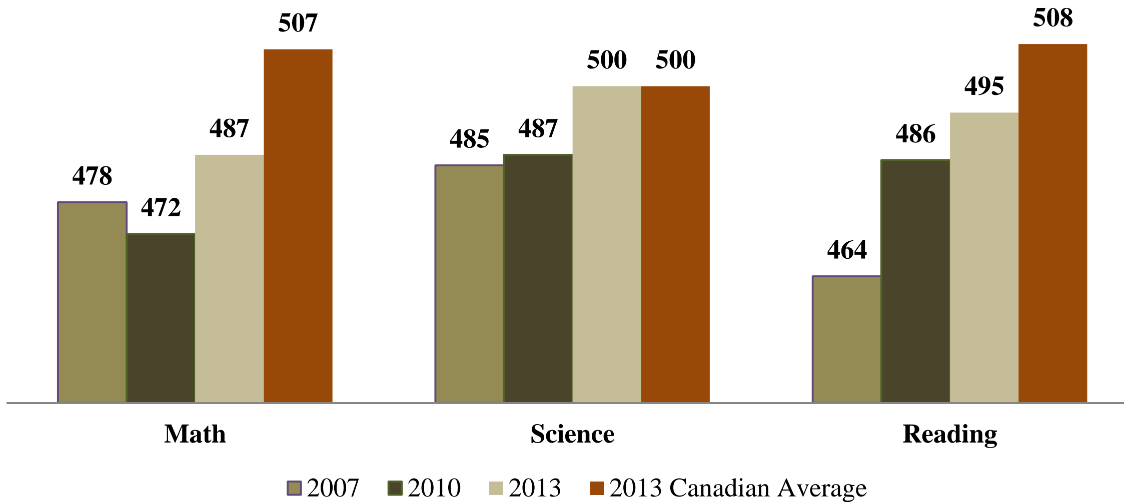
*Pan-Canadian Assessment*

Students, aged 13 years old, throughout the country are assessed every three years using standardized tests in the areas of Math, Science and English. The results are used to determine whether students across Canada reach similar levels of performance at approximately the same time in their schooling. Standardized testing was completed in 2007, 2010 and 2013.

Chart 5 shows the Pan-Canadian Assessment results for Newfoundland and Labrador for 2007, 2010 and 2013 and also includes the Canadian results for 2013.

**Chart 5**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Pan-Canadian Assessment – Three Year Results**
**School Years Beginning September 1**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Council of Ministers of Education, Canada's Pan-Canadian Assessment program reports (unaudited).

Since 2007, the results show an improvement in all three subject areas for students in Newfoundland and Labrador. The Province's results were generally below the average Canadian score.

# Detailed Observations

## 1. Goals, Objectives and Evaluation of the Teacher Allocation Model

**Objectives**

To determine whether the Department had goals and measurable objectives for the Teacher Allocation Model.

### Conclusion

The Department of Education and Early Childhood Development did not formally document the goals and objectives for the Teacher Allocation Model. The goals were not linked to intended results and the objectives for the Teacher Allocation Model were not specific, measurable and did not include set time frames.

To determine whether the Department had assessed the outcomes of implementing the Teacher Allocation Model.

### Conclusion

The Department of Education and Early Childhood Development has not formally evaluated the Teacher Allocation Model to determine whether the intended results were achieved.

**Overview**

In order to determine whether an initiative is having the desired results, expected goals and objectives should be articulated as part of the decision process and should form part of the design and implementation of the initiative. Actual results should be assessed against expected outcomes.

We assessed our objective related to the goals, objectives and evaluation of the Teacher Allocation Model against the following criteria:

A. The Department established goals for the Teacher Allocation Model.

B. The Department established specific objectives for the Teacher Allocation Model.

C. The Department evaluated the Teacher Allocation Model to determine whether the intended results were achieved.

**Cost of the Teacher Allocation Model**

The cumulative incremental cost of the revised Teacher Allocation Model is estimated to be approximately $143.7 million, as detailed in Table 1.

**Table 1**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Estimated Incremental Cost of Teacher Allocation Model**
**For School Years Beginning September 1, 2008 to September 1, 2014**

| School Year | Full-Time Equivalent Teachers | Full-Time Equivalent Students | 2007-08 Pupil Teacher Ratio (PTR) | Number of Teachers Based on 2007-08 PTR | Estimated Teachers Maintained | Teacher Average Salary | Estimated Incremental Cost |
|---|---|---|---|---|---|---|---|
| 2008-09 | 5,531 | 68,000 | 12.7 | 5,354 | 177 | $62,360 | $ 11,017,097 |
| 2009-10 | 5,527 | 67,061 | 12.7 | 5,280 | 247 | $70,679 | 17,429,887 |
| 2010-11 | 5,502 | 66,122 | 12.7 | 5,206 | 296 | $74,245 | 21,942,613 |
| 2011-12 | 5,488 | 65,233 | 12.7 | 5,136 | 352 | $77,744 | 27,330,382 |
| 2012-13 | 5,469 | 64,836 | 12.7 | 5,105 | 364 | $78,318 | 28,492,335 |
| 2013-14 | 5,308 | 64,559 | 12.7 | 5,083 | 225 | $79,094 | 17,765,633 |
| 2014-15 | 5,327 | 64,495 | 12.7 | 5,078 | 249 | $79,326 | 19,724,691 |
| **Total Estimated Incremental Cost** | | | | | | | **$143,702,638** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Education and Early Childhood Development (unaudited).

This represents an average annual additional expenditure of public money of approximately $20,000,000 to implement the revised Teacher Allocation Model.

## 1A. Goals of the Teacher Allocation Model

### Introduction

Upon approving the recommendations of the Teacher Allocation Commission Report in February 2008, Cabinet directed the Department to complete an evaluation of the Teacher Allocation Model at the end of three years after implementation (i.e. after the 2010-11 school year). This is a clear indication that there was an expectation from Government that the additional resources being allocated to teaching resources would achieve certain measureable goals and objectives.

**Goals of the Teacher Allocation Model**

Goals are specific, documented, statements of the desired results to be achieved over a specified period of time. Goals are accompanied by performance measures and indicators.

Although not formally documented, the Department indicated that the goals for the Teacher Allocation Model were to:

- comply with legislative requirements;
- allocate teaching units to school boards to deploy to schools using formulas, ratios, and a needs based approach;
- ensure students have equal access to programs in all areas of the Province;
- increase instructional focus; and
- address increased need in growth areas.

The Department's goals of the Teacher Allocation Model are not statements of the desired results. These stated goals are operational in nature, and linked to outputs from the model and not linked to outcomes of implementing the model. In addition, the goals were not linked to a particular time frame.

If the goals of the Teacher Allocation Model are not specifically identified, documented and linked to intended results, the Department will be unable to measure the success of the Teacher Allocation Model.

**Finding**

1. The Department of Education and Early Childhood Development did not establish goals for the revised Teacher Allocation Model, which was provided with approximately $20 million annually to implement, that indicate desired results or the timeframe to achieve those results.

## 1B. Objectives of the Teacher Allocation Model

**Introduction**

Objectives are measurable milestones which specify a change or benefit that the entity hopes to achieve. An important principle in establishing objectives is that they should be specific, measurable, achievable, and have time lines in the short term. Objectives allow an organization to measure success and progress toward their goals. Without objectives it is difficult to determine whether goals are being met.

### Objectives of the Teacher Allocation Model

Although not formally documented, the Department indicated that the objectives of the Teacher Allocation Model were to:

- allocate appropriate levels of special education services and support inclusive education practices;
- make provisions for emergent requests;
- phase in class size caps;
- enhance specialist allocations;
- enhance programming;
- enhance administration allocations; and
- introduce Education Officers to support school development, student achievement, and instructional leadership.

These objectives are not specific, measurable or have any set time frames. These objectives focus on implementing the Teacher Allocation Model as opposed to what results the model was expected to achieve.

**Finding**

2. The Department of Education and Early Childhood Development did not establish specific, measurable objectives for the revised Teacher Allocation Model.

## 1C. Evaluation of Outcomes of the Teacher Allocation Model

### Introduction

Given the high cost of the revised Teacher Allocation Model and the importance of teaching resources to the education system, the Department should have a formal evaluation framework that includes documented goals, specific objectives, performance indicators, outputs and outcomes. The reporting and evaluation of performance measures and progress towards objectives and goals should be completed at least annually and consideration given as to whether changes in strategy, goals or outcomes are required.

The evaluation process should include a system of performance indicators for measuring goals and objectives, comparing actual outcomes to targeted outcomes, and determining whether overall goals have been met. If outcomes are not met, then corrective action can be taken.

It is also important to distinguish between outputs from outcomes. Outputs are what is produced - the measureable products of activities. In this case, the outputs of the Teacher Allocation Model are the number and types of teachers to be deployed in specific categories. The outcomes are the impact made by these outputs such as increased achievement, equal access to programs, or the improved learning and education of students.

**Measurement of Objectives**

The Department indicated that the objectives of the Teacher Allocation Model were measured using the following results:

- special education services were adjusted to support inclusive education practices as a result of consultations with school districts;

- the needs based model allowed for the yearly review of identified needs, the yearly opportunity to address new priorities and allowed Districts to petition the Department when needs exceeded allocations;

- class size caps were phased in over time and it was decided to keep the smallest class sizes in primary grades where research shows class size matters most;

- specialist allocations were enhanced and needs based allocations provided opportunity for the Districts to use units to increase specialist allocations in Fine Arts, French, Physical Education, and Skilled Trades programming; and

- the instructional focus was increased with the addition of education officers and the increased administration allocation.

These results focus on the outputs of the Teacher Allocation Model rather than the outcomes. Without measurable objectives that have a specific target, it would be difficult for any evaluation of results to identify variances and provide meaningful comparisons on which to base future allocation decisions.

**Finding**

3. The Department of Education and Early Childhood Development was unable to compare actual outcomes to specific targets because the objectives established were not specific, measureable, or time based.

**Evaluation of Teacher Allocation Model**

Upon approving the recommendations of the Teacher Allocation Commission Report in February 2008, Cabinet directed the Department to complete an evaluation of the Teacher Allocation Model at the end of three years after implementation (i.e. after the 2010-11 school year). The Department has not formally evaluated the Teacher Allocation Model since the implementation of the recommendations and the evaluation requested by Cabinet was never submitted.

While Department officials advised that the Teacher Allocation Model had allocation changes made since 2013 as part of the annual budgetary assessment process, the Department has not developed an evaluation framework to periodically evaluate the Teacher Allocation Model in order to determine the impact of increasing or decreasing teaching units, whether intended results were achieved and whether changes in the strategy were required.

## Findings

4. Despite being directed by Cabinet to evaluate the Teacher Allocation Model three years after it was implemented in 2008-09, the Department of Education and Early Childhood Development has not completed the assessment and has not reported back to Cabinet.

5. The Department of Education and Early Childhood Development did not develop an evaluation framework to periodically evaluate the Teacher Allocation Model in order to determine the impact of increasing or decreasing teaching units, whether intended results were achieved and whether changes in the strategy were required.

## 2. Allocation and Deployment of Teachers

**Objective**

To determine whether teachers were allocated and deployed in accordance with the Teacher Allocation Model and guidance.

### Conclusion

Teachers were not always allocated and deployed in accordance with the Teacher Allocation Model and guidance.

**Overview**

The Department is responsible for determining the total number of units to be allocated to the District. In April of each year, the Department provides the Districts with the teaching units to be allocated in each category as well as the total units for the coming school year. The deployment of teachers to individual schools is the responsibility of the Districts. The Districts have some flexibility to vary the units in each category but is expected to remain within the total units allocated for the year.

We assessed the allocation, deployment and assignment of teachers against the following criteria:

A. The Department provides guidance to apply the Teacher Allocation Model.

B. The Department and the District have applied the Teacher Allocation Model in accordance with the guidance.

C. Deployment outside of the Teacher Allocation Model is appropriately documented and approved.

We examined the Department's and the District's Teacher Allocation Models for the 2014-15 school year. We also examined a sample of 49 of 257 schools for the 2014-15 school year to determine whether the assignment of teachers in each school was in accordance with teaching units allocated by the Teacher Allocation Model and whether the assignment of needs-based teachers was documented and supported.

## 2A. Guidance in Applying the Teacher Allocation Model

### Introduction

The Department's Teacher Allocation Model policy for the 2014-15 school year included guidelines to allocate teaching units to the provincial K-12 system. It specified maximum class sizes for multi-grades and for grades K to 9 and provided ratios for high school. It identified the appropriate ratios for guidance counsellors, learning resource teachers, instructional resource teachers, specialist teachers, administrators and various itinerant teachers. It also detailed various procedures with respect to the Department responsibilities and Department approvals.

### Guidance Provided by the Department

Verbal guidance was provided by the Department to the District when changes were made to the allocation model.

The District provided us with their Teacher Allocation Guidelines for the 2014-15 school year. The categories and ratios included in the District's Teacher Allocation Guidelines were similar to the Department's policy, with some minor exceptions related to multi-grading and specialist teachers, which the Department acknowledged as exceptions.

### Finding

6. The allocation methodology used by the Newfoundland and Labrador English School District was generally in accordance with guidance provided by the Department of Education and Early Childhood Development.

## 2B. Allocation and Deployment of Teachers

### Introduction

The Teacher Allocation Model has two components:

- Component 1 is the ratio-based component where ratios are applied to the student population to generate the number of teachers in a defined category. These categories are classroom teachers, administrators, specialists, guidance counsellors, special education teachers, learning resource teachers and english as a second language teachers.

- Component 2 is the needs-based component to meet identified needs beyond the ratio-based component. These categories are itinerants for the blind and visually impaired, itinerants for the deaf and hard of hearing, speech language pathologists, educational psychologists, identified needs, pervasive needs, student support services itinerants, safe and caring schools itinerants, and numeracy support teachers.

**Department Allocation of Teachers**

*Component 1 Teachers*

Based on our analysis of the Department's teacher allocation database and a sample of 49 schools for the 2014-15 school year, we found that the determination of Component 1 teaching units was calculated correctly.

*Component 2 Teachers*

The identified and pervasive needs categories for Component 2 units were generally determined from meetings between the Department and the District. The District requests the number of units required and, through discussions with the Department, would arrive at the total units to be allocated for the upcoming school year.

The allocation of Component 2 teaching units for itinerant teachers for the blind and visually impaired, itinerants for the deaf and hard of hearing, speech language pathologists, educational psychologists have not changed since 2008.

The Department did not have any documentation to support the allocation decisions for Component 2 teaching units for the 2014-15 school year.

**Findings**

7. The Department of Education and Early Childhood Development applied the Teacher Allocation Model for Component 1 teaching units in accordance with its policies and guidance.

8. The Department of Education and Early Childhood Development did not have any documentation to support the allocation decisions for Component 2 teaching units for the 2014-15 school year.

**District Deployment of Teachers**

The deployment of teachers is the term used by the District to describe the number of units allocated to a school.

The District has an informal process for the District Executive to approve the deployment of teachers to individual schools.

*Component 1 Teachers*

The District determined component 1 units by applying the Teacher Allocation Model to the projected enrolment numbers estimated in the Spring before the school year begins. We examined the deployment of all Component 1 categories for all schools, except for classroom teachers, and identified the following differences:

- for guidance counsellors, the District deployed 22 more units than the Teacher Allocation Model prescribed. The District rounded up or down to the nearest .25 unit based on need. The Teacher Allocation Model doesn't provide for the rounding of guidance counsellors; and

- for specialists, the District deployed 6.5 more units than the Teacher Allocation Model prescribed. The District rounded up or down to the nearest .25 unit based on need, instead of using the prescribed rounding tables in the Teacher Allocation Model.

We examined the deployment of classroom teachers for our sample of 49 schools, and found that the District was deploying classroom teachers in accordance with the Teacher Allocation Model.

*Component 2 Teachers*

For component 2 categories, only the identified and pervasive needs were determined by the District and deployed to individual schools as the allocation for the other component 2 categories were determined by the Department. The District deployed identified and pervasive needs teachers to schools based on the documented needs of students that require special services registered in a school. For the 2014-15 school year, most regions used 0.25 of a unit as a guideline for deployment for each student that met the criteria for pervasive needs. For our sample of 49 schools, our examination identified that regions were deploying pervasive needs teaching units inconsistently across the Province. Our examination identified that 24 of the 49 schools had ratios different than the 0.25 units per student.

### Findings

9. The Newfoundland and Labrador English School District did not always deploy Component 1 teachers, such as guidance counsellors and specialists in accordance with the Teacher Allocation Model.

10. The Newfoundland and Labrador English School District was deploying classroom teachers in accordance with the Teacher Allocation Model.

11. The Newfoundland and Labrador English School District did not deploy Component 2 pervasive needs teachers consistently throughout the Province.

**District Assignment of Teachers**

Assignment is the process of school administrators assigning a teacher to a position in a particular school. For the 49 schools in our sample, we assessed whether the assignment of teachers in each school agreed with the units deployed by the District. Our examination identified that teachers were assigned in accordance with the District's deployment decisions.

## Finding

12. Schools were assigning teachers in accordance with the Teacher Allocation Model and Newfoundland and Labrador English School District deployment decisions.

## 2C. Teacher Deployment Outside of the Teacher Allocation Model

### Introduction

Each Spring, the Department sends an allocation letter to the Districts for the upcoming school year that outlines the units by category and the total units allowed for the school year. The District is given flexibility to reallocate units within the Component 1 categories, however, any variation in Component 2 categories would require prior approval by the Minister of Education and Early Childhood Development.

### Comparison of Department and District Units

Table 2 shows the Department allocation and the District deployment for the 2014-2015 school year.

**Table 2**

**Department of Education and Early Childhood Development**
**Teacher Allocation in Schools**
**Teacher Allocation and Deployment**
**School Year Beginning September 1, 2014**

| | Teaching Units | | |
|---|---|---|---|
| **Teacher Category** | **Department Allocation** | **District Deployment** | **Difference** |
| **Component 1 - Population based** | | | |
| Classroom Teachers<br>Kindergarten | 339.00 | 173.00 | -166.00 |
| Grade 1 | 246.00 | 266.00 | 20.00 |
| Grade 2 | 269.00 | 267.00 | -2.00 |
| Grade 3 | 255.00 | 266.50 | 11.50 |
| Grade 4 | 260.00 | 259.50 | -0.50 |
| Grade 5 | 260.00 | 267.50 | 7.50 |
| Grade 6 | 268.00 | 280.00 | 12.00 |
| Grade 7 | 239.00 | 247.75 | 8.75 |

| Teacher Category | Teaching Units | | |
|---|---|---|---|
| | **Department Allocation** | **District Deployment** | **Difference** |
| Grade 8 | 239.00 | 245.10 | 6.10 |
| Grade 9 | 244.00 | 266.85 | 22.85 |
| High school | 736.22 | 717.1 | -19.12 |
| Total Classroom Teachers | 3,355.22 | 3,256.30 | -98.92 |
| Administrators | 291.75 | 291.25 | -0.50 |
| Specialists | 375.50 | 405.52 | 30.02 |
| Special Education | 469.56 | 475.00 | 5.44 |
| Guidance Counsellors | 134.16 | 157.90 | 23.74 |
| Learning Resources | 67.06 | 66.47 | -0.59 |
| English as a Second Language | 12.00 | 11.00 | -1.00 |
| Teachers of the Deaf | 4.00 | 4.00 | 0.00 |
| Identified needs | 147.00 | 178.83 | 31.83 |
| District Adjustments | | 2.50 | 2.50 |
| **Total Regular Teaching Units** | **4,856.25** | **4,848.77** | **-7.48** |
| **Component 2 - Needs-Based** | | | |
| Itinerants for blind and visually impaired | 9.00 | 8.25 | -0.75 |
| Itinerants for the deaf and hard of hearing | 18.00 | 18.00 | 0.00 |
| Speech Language Pathologists | 45.00 | 45.00 | 0.00 |
| Educational Psychologists | 43.00 | 42.00 | -1.00 |
| Pervasive needs | 314.50 | 325.28 | 10.78 |
| Student Support Services itinerants | 11.00 | 16.00 | 5.00 |
| Safe and Caring Schools itinerants | 6.00 | 6.00 | 0.00 |
| Numeracy Support Teachers | 14.00 | 14.00 | 0.00 |
| **Total Needs-Based Teaching Units** | **460.50** | **474.53** | **14.03** |
| **Total Teaching Units** | **5,316.75** | **5,323.30** | **6.55** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon information obtained from the Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District.

The greatest difference between the Department allocation and the District deployment was for Kindergarten. This difference resulted as the Department allocated one full teaching unit to Kindergarten even though most schools in the Province only offered Kindergarten for ½ day. As such, the District only deployed and assigned 0.5 of a unit resulting in an extra allocation of 166 units available to the District. The Department was aware of the over allocation but could not provide documentation on why it was allocated this way. This Kindergarten allocation had been done this way since 2000 to increase flexibility to the District.

This over allocation allowed the District to deploy additional units in other Component 1 categories.

## Finding

13. The Department of Education and Early Childhood Development allocated one full teaching unit to Kindergarten even though most schools in the Province only offered Kindergarten for ½ day and required only 0.5 of a teaching unit. As a result, the Department of Education and Early Childhood Development allocation did not accurately reflect the needs of the Newfoundland and Labrador English School District. The Newfoundland and Labrador English School District used the additional units for other grades and categories.

# Recommendations

1. The Department of Education and Early Childhood Development should, with the assistance of the Newfoundland and Labrador English School District, establish a formal evaluation framework that includes documented goals, specific objectives, performance indicators, expected outputs and expected outcomes. The Department of Education and Early Childhood Development should use this framework to periodically evaluate the Teacher Allocation Model to determine whether intended results are being achieved.

2. The Department of Education and Early Childhood Development should determine whether an evaluation of the Teacher Allocation Model as directed by Cabinet is still required.

3. The Department of Education and Early Childhood Development should ensure that the Teacher Allocation Model reflects the teaching needs of Kindergarten classes.

4. The Department of Education and Early Childhood Development should ensure that the deployment for all Component 2 - needs-based teachers is supported, consistently applied amongst all Newfoundland and Labrador English School District regions and based upon the special needs of students each year.

5. The Newfoundland and Labrador English School District should ensure that the deployment of all needs-based teachers is supported and communicated to the Department of Education and Early Childhood Development.

# Department Response

***Recommendation #1***

*The Department of Education and Early Childhood Development, in consultation with school districts, and informed by research and a jurisdictional review, will explore the development of a framework to evaluate the effectiveness of the Teacher Allocation Model.*

***Recommendation #2***

*The Department of Education and Early Childhood Development will report findings back to Cabinet and determine if a formal evaluation on the Teacher Allocation Model is still required. A formal evaluation has not been completed to date given the number of changes to the allocation model, approved through budget decisions, over multiple years.*

***Recommendation #3***

*The Department of Education and Early Childhood Development will ensure that the Teacher Allocation Model accurately reflects the teaching needs of Kindergarten classes.*

***Recommendation #4***

*The Department of Education and Early Childhood Development will ensure that the Teacher Allocation Model will include allocation for district identified priorities through Component 2 – needs based teachers.*

*The Department of Education and Early Childhood Development will work collaboratively with school districts regarding the use of Component 2 – needs based teachers throughout the province to support the needs of students with exceptionalities identified annually. The model provides flexibility to school districts to deploy based on individual student needs and local school circumstances.*

*The Department of Education and Early Childhood Development will work collaboratively and communicate regularly with school districts on the deployment of Component 2 - needs based teachers.*

# District Response

***Recommendation #5***

*The District agrees with this recommendation and maintains open and constant communication with DEECD to ensure that programming needs and resulting deployments are understood by all. Throughout the audit process, the District has provided information to explain the differences between the allocation and the deployment of units. The District's allocation for this finite resource is deployed to meet projected school needs and, as the audit has demonstrated, was deployed differently than allocated in response to those needs. The District will collaborate with the DEECD to ensure formal reporting of deployment documentation is communicated.*

# PART 3.2

## DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT

## CHILD PROTECTION SERVICES

# Summary


## Introduction

The *Children and Youth Care and Protection Act* provides the Department of Children, Seniors and Social Development with the legislative authority to deliver services to children, youth and families with a clear purpose "*to promote the safety and well-being of children and youth who are in need of protective intervention*". The Department delivers its child protection services to children and families through three main programs:

Protective Intervention Program - is designed to help ensure the safety and well-being of children who are at risk of maltreatment by a parent. Social workers identify risks to children and work with families to reduce the risks by identifying services and interventions necessary to assist parents with caring for their children in the family home. As at March 31, 2015, there were 4,793 children living in their family homes under this program.

Kinship Services Program - is a voluntary and collaborative program available to families when an assessment of safety and risk factors indicates that it is necessary for children to live away from their parents. As at March 31, 2015, there were 504 children living with relatives or significant others in kinship living arrangements.

In-Care Program - is provided for children that have been removed from the family home by a social worker normally under a warrant issued by the court when children are no longer safe in the family home and kinship services are not available. As at March 31, 2015, there were 955 children living in foster or staffed residential homes under the care of the Department of Children, Seniors and Social Development.

Department expenditures for the year ended March 31, 2015 totaled $135 million, of which approximately $74.5 million was financial support paid in connection with 6,252 children under the Protective Intervention, Kinship Services and In-Care Programs.

## Objectives

The objectives of our audit were to determine whether the Department of Children, Seniors and Social Development:

1. Responds to allegations of child maltreatment in a timely and appropriate manner;

2. Complies with its policies and procedures to effectively manage the safety, well-being and development of children in the Protective Intervention Program;

3. Delivers Kinship Services in accordance with its policies and procedures;

4. Complies with its policies and procedures to effectively manage the safety, well-being and development of children in the In-Care Program; and

5. Effectively assesses the quality of its child protection programs.

## Scope

Our audit covered the period April 1, 2013 to March 31, 2015 and included an examination of child protection services that were provided by the Department of Children, Seniors and Social Development under the Protective Intervention, Kinship Services and In-Care Programs. Our audit did not include the Youth Services Program.

Our audit procedures included the testing of case files using non-statistical, random sampling methods and conducting detailed inspection of documentation maintained by the Department of Children, Seniors and Social Development. As well, we analyzed and used data from the Client Referral Management System. We interviewed Departmental officials including those in district offices.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in May 2016.

## Importance to Newfoundlanders and Labradorians

The Department of Children, Seniors and Social Development investigates allegations of child maltreatment and provides interventions to protect the safety and well-being of children. As at March 31, 2015, there were 6,252 children, or approximately 8% of the child population of the Province, under the protection of the Department of Children, Seniors and Social Development. Therefore, it is important that the Department of Children, Seniors and Social Development have effective programs in place to protect these children.

## Conclusions

**Objective 1**

The Department of Children, Seniors and Social Development does not always respond to allegations of child maltreatment in a timely and appropriate manner.

**Objective 2**

The Department of Children, Seniors and Social Development does not always comply with its policies and procedures to effectively manage the safety, well-being and development of children in the Protective Intervention Program.

**Objective 3**

The Department of Children, Seniors and Social Development does not always deliver Kinship Services in accordance with its policies and procedures.

**Objective 4**

The Department of Children, Seniors and Social Development does not always comply with its policies and procedures to effectively manage the safety, well-being and development of children in the In-Care Program.

**Objective 5**

The Department of Children, Seniors and Social Development does not effectively assess the quality of its child protection programs.

## Findings

**Referrals and Investigations**

1. Child Protection Referral and Intake Report Forms, which document social worker screening and response priority decisions relating to allegations of child maltreatment, were not always reviewed and approved by supervisors within 24 hours, as required by the Risk Management Decision Making Model.

2. Supervisor review and approval of social worker screening and response priority decisions were not always documented on Intake Report Forms in the Client Referral Management System, as required by the Risk Management Decision Making Model.

3. Social workers did not always complete Safety Assessment Forms to document whether children were safe in the family home when commencing protection investigations.

4. Supervisors did not always document their review and approval of Safety Assessment Forms. When approval was documented, it was not always documented in a timely manner.

5. Social workers did not always complete, and supervisors did not always review and approve Safety Plan Forms when children were assessed as being unsafe in their family home during protection investigations.

6. Children were placed in out-of-home living arrangements under a safety plan when the Department of Children, Seniors and Social Development did not have policies and procedures to address children living in out-of-home living arrangements under a safety plan. Policies and procedures were subsequently established in December 2015.

7. Social workers did not always complete Assessment Investigation Summaries within 30 days to document whether allegations of child maltreatment were verified and protective intervention was required.

8. Supervisors did not always review and approve Assessment Investigation Summaries, and when Assessment Investigation Summaries were reviewed and approved, they were not always reviewed and approved in a timely manner.

9. There was no evidence that the Department of Children, Seniors and Social Development investigated why the Central East region screened out Child Protection Referrals at a higher rate than the other three regions in the Province.

**Protective Intervention Program**

10. Social workers did not always complete Risk Assessment Instruments when required. When Risk Assessment Instruments were completed in our sample, they were completed late 55% of the time.

11. Supervisors did not always approve Risk Assessment Instruments and when they were approved they were not approved in a timely manner in 22% of our sample. Delays in supervisor approval averaged 214 days.

12. Social workers did not always complete and supervisors did not always approve Family Centered Action Plans which are intended to address the risks identified in Risk Assessment Instruments.

13. The highest risks of future maltreatment of children identified in Risk Assessment Instruments were not always clearly included on Family Centered Action Plans, as required by the Risk Management Decision Making Model.

14. Risks identified and included on Family Centered Action Plans were not clearly linked to Family Centered Action Plan activities designed to reduce those risks.

15. The majority of activities listed on Family Centered Action Plans in our sample were not measureable and we could not determine whether these activities were achieved and risks were reduced.

16. Some family homes which were assessed by social workers as having a higher risk of future maltreatment of children were visited less frequently than lower risk family homes.

17. Multiple social workers made visits to the same family home during the audit period, which increases the risk that working relationships and case file progress may be adversely affected.

18. Social workers did not always clearly document whether Family Centered Action Plan activities, which are intended to reduce risks to children, were completed.

19. Social workers did not always document the results of visits to family homes in a timely manner.

**Kinship Services Program**

20. Social workers did not always complete Kinship Home Assessments in accordance with the Protection and In-Care Policy and Procedure Manual to determine whether kinship homes were safe and supportive for children.

21. Regional managers did not always approve Kinship Home Assessments when children were placed in kinship homes with people with criminal records.

22. Regional managers did not always approve Kinship Home Assessments when children were placed in kinship homes with people that were previously clients with child protection services of the Province.

23. The Department of Children, Seniors and Social Development did not always provide evidence that social workers completed home assessments to determine whether caregiver homes approved under the Child Welfare Allowance Program were safe and supportive for children.

24. The Department of Children, Seniors and Social Development did not reassess caregiver homes approved under the Child Welfare Allowance Program when it implemented an enhanced kinship home assessment process on October 1, 2013.

25. The Department of Children, Seniors and Social Development may not know whether children living in caregiver homes approved under the Child Welfare Allowance Program are safe because it did not require a vulnerable sector check for people 18 years of age or older who were living in these homes.

26. Department of Children, Seniors and Social Development policy allows children to be placed in kinship homes prior to the receipt of criminal record and vulnerable sector check documentation from the police for people living in the kinship home.

27. Supervisors and regional managers approve kinship homes when key information is not documented on the Kinship Home Assessment Form.

28. Social workers did not assess whether parents were able to financially support their children in kinship living arrangements in 35 of the 36 kinship files we examined, as required by the Protection and In-Care Policy and Procedure Manual.

29. Social workers did not always prepare and review Kinship Care Agreements to document whether children's needs were addressed and that they were in safe and supportive kinship homes.

30. Children living in kinship homes receive less financial support than children living in relative foster homes when the only substantive difference in their living arrangements is that the Department of Children, Seniors and Social Development has legal responsibility for children in relative foster homes.

31. Financial support provided to relative foster homes is increased by $7,000 per year when the foster parents choose to complete a 21 hour training course, which is not mandatory.

32. Children living in kinship homes receive less monitoring by social workers than children living in relative foster homes when the only substantive difference in their living arrangements is that the Department of Children, Seniors and Social Development has legal responsibility for children in relative foster homes.

**In-Care Program**

33. Social workers did not always comply with the Protection and In-Care Policy and Procedure Manual when placing children with placement resources.

34. In-Care Progress Reports were not always completed to address the service needs of children In-Care, as required by the Protection and In-Care Policy and Procedure Manual.

35. In-Care Progress Report goals and tasks were clearly linked to the identified needs of children in our sample, however most goals and tasks were not measureable and the timeframes for completion were not always established.

36. The Department of Children, Seniors and Social Development has not established time to permanency expectations for children In-Care.

37. A significant number of children in our sample had been in the interim care, interim custody or temporary custody of the Department of Children, Seniors and Social Development for a period of time that exceeded established legislated timeframes.

38. Some children in the interim care, interim custody or temporary custody of the Department of Children, Seniors and Social Development had been placed with numerous placement resources and had numerous social workers assigned to their file, which increases the risk that the children's well-being and development will not be supported.

39. In-Care Progress Reports were not always prepared within six months of a child entering In-Care. For our sample, the number of days late averaged 368 days.

40. In-Care Progress Reports were not always prepared every six months while a child was In-Care. For our sample, the number of days late averaged 128 days.

41. The Department of Children, Seniors and Social Development does not have systems in place to readily determine and monitor the level of social worker in-person contact with children and placement resources.

42. Social workers did not always visit children and their placement resources every month to review and assess child progress, as required by the Protection and In-Care Policy and Procedure Manual.

43. There were significant delays between social worker visits and documentation of those visits in CRMS.

44. Social workers did not always document whether In-Care Progress Report work plan tasks were achieved and goals were met, as required by the Protection and In-Care Policy and Procedure Manual.

45. Social workers did not always conduct case conferences with the In-Care Planning Team, as required by the Protection and In-Care Policy and Procedure Manual.

46. Social workers did not always complete annual reviews of regular foster homes to determine whether they continue to meet the approval requirements of the Department of Children, Seniors and Social Development. When annual reviews were completed in our sample, the majority were completed late by an average of 254 days.

47. While the Department of Children, Seniors and Social Development requires that people residing in regular foster homes complete a criminal records check every five years, the Department does not require that a vulnerable sector check be completed every five years.

48. Relative foster homes are not subject to an annual review to determine whether they continue to meet the Department of Children, Seniors and Social Development's approval requirements.

**Governance**

49. The Department of Children, Seniors and Social Development had not established results-oriented goals and performance expectations to address program and service delivery system performance.

50. The Department of Children, Seniors and Social Development did not identify and monitor performance indicators to measure the performance of its Protective Intervention and In-Care Programs.

51. The Quality Assurance Division has not developed comprehensive policies and procedures to support and guide its activities.

52. The Quality Assurance Division does not prepare annual work plans.

53. The Quality Assurance Division cannot readily access case file data to effectively monitor whether child protection programs are delivered in accordance with policies and procedures.

54. The Department of Children, Seniors and Social Development does not report to the public on the performance of its child protection programs.

## Recommendations

1. The decisions of social workers in response to allegations of child maltreatment should be reviewed and approved by supervisors in accordance with the Risk Management Decision Making Model.

2. Social workers should complete and supervisors should review and approve safety assessments, safety plans and protection investigations in accordance with the Risk Management Decision Making Model.

3. Social workers should complete and supervisors should approve Risk Assessment Instruments and Family Centered Action Plans for children in the Protective Intervention Program in accordance with the Risk Management Decision Making Model.

4. Risks to children included on Family Centered Action Plans should be clearly linked to the activities required to reduce those risks.

5. Activities included on Family Centered Action Plans to reduce risks to children should be measureable.

6. Social workers should document on the Family Centered Action Plan whether activities were achieved by the completion dates set and whether risks to children were reduced.

7. Social workers should visit higher risk family homes more frequently than lower risk family homes. The results of these visits should be documented in a timely manner.

8. Social workers should complete and regional managers should approve Kinship Home Assessments prior to placing children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.

9. The Department of Children, Seniors and Social Development should consider reassessing kinship homes that were approved under the previous Child Welfare Allowance Program.

10. The Department of Children, Seniors and Social Development should address the risks to children when they are placed in kinship homes prior to receipt of criminal record and vulnerable sector check documentation from the police.

11. The Kinship Home Assessment Form should be revised to clearly indicate all of the people residing in the kinship homes.

12. Social workers should assess whether parents can financially support their children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.

13. Social workers should prepare and review Kinship Care Agreements in accordance with the Protection and In-Care Policy and Procedure Manual.

14. The Department of Children, Seniors and Social Development should review the level of financial support and social worker monitoring provided to children in kinship homes.

15. Social workers should place children In-Care with placement resources in accordance with the Protection and In-Care Policy and Procedure Manual.

16. Social workers should complete In-Care Progress Reports for children in accordance with the Protection and In-Care Policy and Procedure Manual.

17. The goals and tasks in In-Care Progress Report work plans should be measureable and specific timeframes for completion should be set.

18. Social workers should document on the In-Care Progress Report work plan whether goals and tasks were achieved and the service needs of children were met.

19. The Department of Children, Seniors and Social Development should establish time to permanency expectations for children In-Care.

20. Social workers should visit with children In-Care and placement resources once a month in accordance with the Protection and In-Care Policy and Procedure Manual. The results of these visits should be documented in a timely manner.

21. Social workers should complete annual reviews of regular foster homes in accordance with the Protection and In-Care Policy and Procedure Manual.

22. The Department of Children, Seniors and Social Development should consider implementing annual reviews for relative foster homes.

23. The Department of Children, Seniors and Social Development should establish results-oriented goals and performance expectations to address program and service delivery system performance.

24. The Department of Children, Seniors and Social Development should identify and monitor performance indicators to measure the performance of the Protective Intervention and In-Care Programs.

25. The Quality Assurance Division should develop policies and procedures and annual work plans to support and guide its activities, including the investigation of irregular statistical results in referral screen out rates.

26. The Department of Children, Seniors and Social Development should provide the Quality Assurance Division with the accessible data necessary to monitor whether programs are delivered in accordance with Departmental policies and procedures.

27. The Department of Children, Seniors and Social Development should report program performance results to the public.

### Importance of implementing these recommendations

There is an increased risk that children under the protection of the Department of Children, Seniors and Social Development will be maltreated should our recommendations not be implemented.

# Objectives and Scope

## Objectives

The objectives of our audit were to determine whether the Department of Children, Seniors and Social Development (the Department):

1. Responds to allegations of child maltreatment in a timely and appropriate manner;

2. Complies with its policies and procedures to effectively manage the safety, well-being and development of children in the Protective Intervention Program;

3. Delivers Kinship Services in accordance with its policies and procedures;

4. Complies with its policies and procedures to effectively manage the safety, well-being and development of children in the In-Care Program; and

5. Effectively assesses the quality of its child protection programs.

Criteria were developed specifically for this audit based upon relevant legislation, Department policies and procedures, our related work, reviews of literature including reports of other legislative auditors, and discussions with management. The criteria were accepted as suitable by the senior management of the Department, except for two criteria related to objective 2:

i. Risks identified in the Risk Assessment Instrument (RAI) are clearly linked to activities listed in the Family Centered Action Plan (FCAP) which is the primary planning tool to identify interventions targeted at risk reduction; and

ii. The frequency of visits to the family home is based on an assessment of risk.

However, we decided to use both of these criteria because:

- In the case of the first criteria, the Department's own policies and procedures clearly state that risk factors identified for inclusion on the FCAP will be those given the highest rating on the RAI and that FCAP objectives and activities should be developed for the child and family to outline what must be accomplished to reduce these risks.

- In the case of the second criteria, the Department indicated that a minimum contact standard will be required for families based on assessed risk when a new Structured Decision Making Model is implemented in 2017.

## Scope

Our audit covered the period April 1, 2013 to March 31, 2015 and included an examination of child protection services that were provided by the Department under the Protective Intervention, Kinship Services and In-Care Programs. Our audit did not include the Youth Services Program.

Our audit procedures included the testing of case files using non-statistical, random sampling methods and conducting detailed inspection of documentation maintained by the Department. As well, we analyzed and used data from the Client Referral Management System (CRMS). We interviewed Departmental officials including those in district offices.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in May 2016.

# Background

In 2009, the Province created the Department of Child, Youth and Family Services, currently the Department of Children, Seniors and Social Development (the Department), to address systemic issues regarding child protection services that were delivered by the four Regional Health Authorities (RHAs). In particular, a 2008 Clinical Services Review commissioned by the Province in response to the Turner Inquiry, identified the following issues:

- A lack of clear purpose and quality indicators for child protection;
- Inadequate legislation;
- High social worker turnover on case files and inadequate levels of client contact;
- Lack of training and professional development; and
- Lack of timely and accurate data for monitoring and planning.

During 2011-12, staff transitioned from the RHAs to the former Department of Child, Youth and Family Services and a new organizational model was implemented which reduced levels of management and increased frontline supervision and delegated authority throughout the four regions of the Province. Table 1 shows the number of provincial and district offices and staff located in the four regions of the Province as at March 31, 2015.

**Table 1**

**Child Protection Services**
**Number of Provincial and District Offices and Staff by Region**
**As at March 31, 2015**

| Region | Provincial Offices | | District Offices | | | | Total Staff |
|---|---|---|---|---|---|---|---|
| | Number | Staff | Number | Managers | Supervisors | Social Workers/Other | |
| St. John's Metro | 2 | 70 | 6 | 4 | 22 | 217 | **313** |
| Central East | 1 | 3 | 19 | 3 | 15 | 131 | **152** |
| Western | 1 | 1 | 15 | 3 | 11 | 89 | **104** |
| Labrador | - | - | 11 | 3 | 10 | 71 | **84** |
| **Total** | **4** | **74** | **51** | **13** | **58** | **508** | **653** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Children, Seniors and Social Development (unaudited).

In June 2011, the Province introduced the *Children and Youth Care and Protection Act* (the *Act*), providing the Department with the legislative authority to deliver services to children, youth and families with a clear purpose "*to promote the safety and well-being of children and youth who are in need of protective intervention*".

The *Act* defines when a child is in need of protective intervention. Examples of instances where a child is in need of protective intervention include, where a child:

- is being, or is at risk of being physically harmed by the action or lack of appropriate action by a parent;
- is being, or is at risk of being sexually abused or exploited by a parent;
- is being, or is at risk of being physically harmed, sexually abused or exploited, or emotionally harmed by a person and the parent does not protect the child;
- is living in a situation where there is violence or a risk of violence; and
- is living with a parent who has allegedly killed or seriously injured another person.

The Department delivers its child protection services to children and families through three main programs:

**Protective Intervention Program (PIP)**

Most children in PIP live at their family home under the care and custody of their parents. PIP is designed to help ensure the safety and well-being of children who are at risk of maltreatment by a parent. Social workers identify risks to children and work with families to reduce the risks by identifying services and interventions necessary to assist parents with caring for their children in the family home.

**Kinship Services Program**

Children in kinship living arrangements live with relatives or other significant individuals who are willing and capable of providing care. Kinship Services is a program available under PIP when an assessment of safety and risk factors indicates that it is necessary for children to live away from their parents. Parents normally agree with the kinship living arrangement and retain legal custody of their children.

**In-Care Program**

This program is provided for children that have been removed from the family home by a social worker normally under a warrant issued by the court when children are no longer safe in the family home and kinship services are not available. Children are placed in the care of the Department and matched with placement resources (i.e. foster home, staffed residential home). The court may award the Department custody of children following the court ordered removal.

Department expenditures for the year ended March 31, 2015 totaled $135 million, of which approximately $74.5 million was financial support paid under the PIP, Kinship Services and In-Care Programs. Table 2 shows the number of children and the approximate annual and average cost of caring for children by program for the year ended March 31, 2015.

**Table 2**

**Child Protection Services**
**Number of Children in Protection by Program and Cost**
**Year Ended March 31, 2015**

| Program | Number of Children | Annual Cost | Average Cost per Child |
|---|---|---|---|
| PIP | **4,793** | $5 million | $1,000 |
| Kinship Services | **504** | $6.6 million | $13,000 |
| In-Care | **955** | $62.9 million | $65,900 |
| **Total** | **6,252** | **$74.5 million** | **$11,900** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Children, Seniors and Social Development (unaudited).

# Detailed Observations

## 1. Referrals and Investigations

**Objective**

To determine whether the Department responds to allegations of child maltreatment in a timely and appropriate manner.

### Conclusion

The Department of Children, Seniors and Social Development does not always respond to allegations of child maltreatment in a timely and appropriate manner.

**Overview**

Section 11 of the *Act* states "*Where a person has information that a child is or may be in need of protective intervention, the person shall immediately report the information to a manager, social worker or peace officer.*" Information received by the Department alleging child maltreatment is considered a Child Protection Referral (CPR). CPR information is screened and investigated in accordance with standards specified in the Department's Risk Management Decision Making Model (the Model). Between June 3, 2013 and March 31, 2015, the Department received 13,936 CPRs, an average of 21 a day.

We assessed the Department's performance against the following criteria:

A. The Department screens and investigates child protection referrals in accordance with Department policies and procedures.

## 1A. CPR Screening and Investigation

**Introduction**

The Model requires that within 24 hours of receipt of CPR information a social worker must:

- make a screening decision on whether the CPR information received meets the definition of child maltreatment and should be screened in for a protection investigation, or screened out;

- determine the response priority by assessing the danger or risk of harm to the child and deciding whether a protection investigation should commence immediately or within 7 days;

- document CPR information received on a CPR Form and document screening and response priority decisions on an Initial Intake Report (IIR) Form; and

- obtain supervisor review and approval of the CPR and IIR Forms within 24 hours of receipt of CPR information.

In exceptional circumstances, the documentation, review and approval of screening and response priority decisions may be extended up to a maximum of 72 hours.

When a social worker and supervisor determine that a protection investigation is to be carried out, the Model requires that a social worker:

- complete a safety assessment for the child and document it on a Safety Assessment Form within 24 hours of interviewing the child and the parents, and immediately complete a safety plan for the child when the safety assessment indicates that the child is unsafe;

- complete a protection investigation and document the results of their investigation on an Assessment Investigation Summary (AIS) within 30 days of receipt of the CPR; and

- obtain supervisor review and approval of the safety assessment, safety plan and AIS.

We analyzed data provided by the Department to determine whether social workers completed and supervisors reviewed and approved child protection referrals and investigations in accordance with the Model during the period June 3, 2013 to March 31, 2015. We identified non-compliance issues relating to the preparation, review and approval of referral and investigation documents.

**Social Worker Decisions Not Approved by Supervisors Within 24 Hours**

Supervisor review and approval of CPR and IIR Forms allows management to continuously monitor the screening and response priority decisions of social workers. Our analysis of referral data indicated that for 4,170 of the 13,936 referrals received, a supervisor did not review and approve the CPR and IIR Forms within 24 hours as required. Review and approval delays averaged 30 days and ranged from a high of over one year to a low of one day.

The Department limits its ability to know whether the screening and response priority decisions of social workers are appropriate when supervisors do not review and approve CPR and IIR Forms within 24 hours as required.

## Finding

1. Child Protection Referral and Intake Report Forms, which document social worker screening and response priority decisions relating to allegations of child maltreatment, were not always reviewed and approved by supervisors within 24 hours, as required by the Risk Management Decision Making Model.

**Supervisor Approval Not Documented**

The Model requires that supervisors review and approve the CPR and IIR Forms within 24 hours of CPR receipt. A supervisor provides evidence of this review and approval by electronically signing the IIR Form in CRMS. If a supervisor verbally approves the screening and response priority decision, then that verbal approval is documented on the IIR Form by the social worker.

For 6,539 of the 13,936 referrals received, a social worker documented on the IIR Form that a supervisor had provided verbal approval of their screening and response priority decision. However, in 4,952 of these 6,539 cases, a supervisor did not subsequently electronically sign the IIR Form in CRMS, as required, indicating that they had reviewed and approved the CPR and IIR Forms.

The Department limits its ability to know whether supervisors review and approve social worker screening and response priority decisions when supervisors do not document their approval of the IIR Form in CRMS.

## Finding

2. Supervisor review and approval of social worker screening and response priority decisions were not always documented on Intake Report Forms in the Client Referral Management System, as required by the Risk Management Decision Making Model.

**Safety Assessments Not Completed, Reviewed and Approved**

Our analysis of safety assessment data relating to 9,376 referrals screened in during the audit period showed that social workers were not complying with the Model to assess the safety of children during protection investigations. We found that no Safety Assessment Form was completed for 644 referrals screened in. Furthermore, for the 8,732 Safety Assessment Forms that were completed, we found:

- 3,849 were not reviewed and approved by a supervisor until more than 30 days after CPR receipt.

- 175 were not reviewed and approved by a supervisor.

When social workers do not complete and supervisors do not review and approve Safety Assessment Forms as required, there is an increased risk that children are unsafe during protection investigations.

## Findings

3. Social workers did not always complete Safety Assessment Forms to document whether children were safe in the family home when commencing protection investigations.

4. Supervisors did not always document their review and approval of Safety Assessment Forms. When approval was documented, it was not always documented in a timely manner.

**Safety Plans Not Completed, Reviewed and Approved**

As stated in the Model, the safety plan:

- is a short-term tool used by social workers to keep children safe while they complete their protection investigation;

- must be documented on a Safety Plan Form and signed by the parents, social worker and supervisor; and

- must be reassessed by a social worker and supervisor by the review date set by the social worker, to determine whether a child is still in need of protection.

We examined a sample of 36 cases where a safety plan was required to determine whether the plans were completed in accordance with the Model. We identified non-compliance issues in the areas of safety plan preparation, review and approval.

- In 8 of the 36 cases, a social worker did not prepare a Safety Plan Form as required.

- In 7 of the 24 Safety Plan Forms prepared, the Safety Plan Form was not reviewed and approved by a supervisor.

- In 1 of the 24 Safety Plan Forms prepared, the Safety Plan Form was not prepared until 6 days after the child was determined to be unsafe.

- In 22 of the 24 Safety Plan Forms prepared, a social worker did not document on the Safety Plan Form whether the safety plan was reassessed by the social worker and supervisor.

- In 3 of the 24 safety plans prepared, a child was placed in an out-of-home living arrangement during the protection investigation when the Department did not have policies and procedures to address children living in out-of-home living arrangements under a safety plan. Policies and procedures were subsequently established in December 2015.

When social workers do not complete and supervisors do not review and approve Safety Plan Forms, there is an increased risk that children are not protected from danger during protection investigations.

**Findings**

5. Social workers did not always complete, and supervisors did not always review and approve Safety Plan Forms when children were assessed as being unsafe in their family home during protection investigations.

6. Children were placed in out-of-home living arrangements under a safety plan when the Department of Children, Seniors and Social Development did not have policies and procedures to address children living in out-of-home living arrangements under a safety plan. Policies and procedures were subsequently established in December 2015.

**Protection Investigations Not Completed and Approved**

The results of social worker protection investigations must be documented on an AIS and indicate whether allegations of child maltreatment are verified and protective intervention is required. The AIS must be reviewed and approved by a supervisor. Our analysis of CRMS investigation data showed that:

- For 1,207 of the 9,376 referrals screened in, the CRMS data showed that no AISs were completed.
- For the 8,169 referrals where the CRMS data indicated an AIS was completed:
  - 3,687 were not completed within 30 days of CPR receipt, as required by the Model. Delays averaged 110 days and ranged from a high of 877 days to a low of one day.
  - 3,595 were not reviewed and approved by a supervisor in a timely manner. Delays averaged 82 days and ranged from a high of 878 days to a low of eight days.
  - 197 were not approved by a supervisor.

The Department limits its ability to know whether allegations of child maltreatment are verified and protective intervention is required when social workers do not complete the AIS as required and supervisors do not review and approve the AIS in a timely manner.

## Findings

7. Social workers did not always complete Assessment Investigation Summaries within 30 days to document whether allegations of child maltreatment were verified and protective intervention was required.

8. Supervisors did not always review and approve Assessment Investigation Summaries, and when Assessment Investigation Summaries were reviewed and approved, they were not always reviewed and approved in a timely manner.

**Inconsistent CPR Screen-out Rate in Central Region**

The Central East region screened out CPRs at a higher rate than the other three regions in the Province during the period June 3, 2013 to March 31, 2015.

**Table 3**

**Child Protection Services**
**Number of CPRs Screened In and Screened Out by Region**
**During the Period June 3, 2013 to March 31, 2015**

| Region | CPR's Received / Screened | | | | Screened Out (%) |
|---|---|---|---|---|---|
| | In | Out | Other | Total | |
| St. John's Metro | 4,613 | 2,260 | 44 | **6,917** | 32.7% |
| Central East | 1,817 | 1,268 | 9 | **3,094** | 41.0% |
| Western | 1,724 | 639 | 3 | **2,366** | 27.0% |
| Labrador | 1,189 | 262 | 44 | **1,495** | 17.5% |
| Other | 33 | 28 | 3 | **64** | 43.8% |
| **Total** | **9,376** | **4,457** | **103** | **13,936** | **32.0%** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Children, Seniors and Social Development (unaudited).

There was no evidence that the Department investigated why the Central East region screened out CPRs at a higher rate than the other three regions in the Province.

## Finding

9. There was no evidence that the Department of Children, Seniors and Social Development investigated why the Central East region screened out Child Protection Referrals at a higher rate than the other three regions in the Province.

## 2. Protective Intervention Program

**Objective**

To determine whether the Department complies with its policies and procedures to effectively manage the safety, well-being and development of children in the Protective Intervention Program.

### Conclusion

The Department of Children, Seniors and Social Development does not always comply with its policies and procedures to effectively manage the safety, well-being and development of children in the Protective Intervention Program.

**Overview**

Once a social worker determines that ongoing protective intervention is required following a protection investigation, they develop a plan and work with parents to reduce identified risks to children. Children normally remain in the family home as social workers provide supervision and guidance to parents that require support and intervention services to care for their children.

As at March 31, 2015, the Department was monitoring 4,793 children living in the family home under PIP. Financial support paid under this program totaled approximately $5 million during 2014-15, or $1,000 per child.

We assessed the Department's performance against the following criteria:

A. Risk Assessment Instruments are prepared and approved in accordance with the Risk Management Decision Making Model.

B. Family Centered Action Plans are prepared and approved in accordance with the Risk Management Decision Making Model.

C. Risks identified in the Risk Assessment Instrument are clearly linked to activities listed in the Family Centered Action Plan which is the primary planning tool to identify interventions targeted at risk reduction.

D. The frequency of visits to the family home is based on an assessment of risk.

E. The results of social worker visits to the family home are documented and clearly indicate whether progress is being made toward completion of Family Centered Action Plan activities and risks identified in the Risk Assessment Instrument are being reduced.

## 2A. Risk Assessment Instruments

### Introduction

When a social worker determines that ongoing protective intervention is required following a protection investigation, they must assess the risk of future maltreatment of a child living in the family home by completing a Risk Assessment Instrument (RAI) within 60 days of CPR receipt. The RAI assists social workers with assessing the risk of future child maltreatment by:

- focusing on key risk factors;
- increasing objectivity in decision making;
- assisting with minimizing errors in clinical judgment;
- ranking cases along a continuum from low risk to high risk; and
- facilitating the linking of services to identified areas of risk.

Social workers are required to reassess and update the risk of child maltreatment every six months for high or moderately high risk case files and every nine months for medium or moderately low risk case files. The Model requires that all RAIs be approved by a supervisor.

To assess compliance with the Model, we examined a sample of 50 PIP case files to determine whether social workers completed and supervisors approved RAIs in accordance with the Model.

### RAIs Not Completed and Approved

In our examination of 50 PIP case files, we found that RAIs were not completed and approved as required by the Model. In 16 of the 50 files examined, no RAIs were completed during the audit period when one or more were required to be completed. Five of these 16 files were high risk cases.

For the 92 RAIs that were completed, we found that:

- 55% were completed late. The number of days that the RAIs were late averaged 685 days and ranged from a high of over eight years to a low of 33 days.
- Supervisor approval was not provided in a timely manner 22% of the time. Approval delays averaged 214 days and ranged from a high of 817 days to a low of 15 days.
- One RAI was not approved by a supervisor.

The Department limits its ability to effectively provide ongoing protective intervention for children when RAIs are not completed in accordance with the Model.

## Findings

10. Social workers did not always complete Risk Assessment Instruments when required. When Risk Assessment Instruments were completed in our sample, they were completed late 55% of the time.

11. Supervisors did not always approve Risk Assessment Instruments and when they were approved they were not approved in a timely manner in 22% of our sample. Delays in supervisor approval averaged 214 days.

## 2B. Family Centered Action Plans

### Introduction

The Family Centered Action Plan (FCAP) provides the social worker and family with clear and specific guidance to change the conditions or behaviors that create risk to a child. The conditions or behaviors which create risk to children are identified on the RAI. The Model requires that social workers complete an RAI and FCAP with the parents when, following a protection investigation, they determine that a child is in need of ongoing protective intervention, and every six or nine months thereafter depending on the assessed risk. The FCAP must be signed by the parents and social worker and approved by a supervisor.

### FCAPs Not Completed and Approved

In our examination of 50 PIP case files, we found that FCAPs were not completed and approved as required by the Model. In 23 of the 50 files examined, no FCAPs were completed during the audit period when one or more were required to be completed. Eight of these 23 files were high risk case files.

There were 71 instances where an FCAP should have been prepared to address the risks identified in an RAI during the audit period. We found that:

- No FCAPs were prepared to address the risks identified in 25 of the 71 RAIs completed.

- Seven of the FCAPs that were prepared to address the risks in the remaining 46 RAIs were not approved by a supervisor.

The Department limits its ability to effectively provide ongoing protective intervention for children when FCAPs are not completed in accordance with the Model.

## Finding

12. Social workers did not always complete and supervisors did not always approve Family Centered Action Plans which are intended to address the risks identified in Risk Assessment Instruments.

## 2C. Identified Risks and the Family Centered Action Plan

### Introduction

In completing the RAI, social workers must assess 23 risk factors over five areas of influence using a five point scale ranging from zero (no risk) to four (high risk), and provide an overall risk rating that is supported by a descriptive clinical analysis. The Model specifies five overall risk rating options:

- High Risk - Situations that pose the most danger and likelihood of future maltreatment where the social worker identifies a high number of 3 and 4 risk factor ratings on the RAI;
- Moderately High Risk - There is a serious risk of future maltreatment where the social worker identifies several risk factor ratings of 3 and 4 on the RAI;
- Medium Risk - There is a significant risk of future maltreatment where the social worker identifies several risk factor ratings of 2 or 3 on the RAI;
- Moderately Low Risk - There is a relatively low risk of future maltreatment where the social worker identifies most of the risk factor ratings of 2 or lower on the RAI; and
- Low Risk - There is a low or insignificant risk of future maltreatment where the social worker identifies most risk factor ratings of 1 or zero on the RAI.

The Model requires that the FCAP include the highest risk factors identified on the RAI. To address these risk factors, the FCAP must include:

- objectives that are measureable;
- activities required by parents and others to achieve the objectives that were developed; and
- activity start and completion dates and the people responsible for completing the activity.

In order for an FCAP to be effective in measuring client progress, the highest risks to children identified on the RAI should be clearly specified and linked to activities that are designed to reduce those risks.

To assess compliance with the Model, we examined 50 PIP case files to determine whether the highest risks identified on RAIs were included on the FCAPs and whether measureable activities were clearly linked to those risks. We identified non-compliance issues relating to FCAP preparation.

**Highest Risks Not Included on FCAPs**

We identified 247 moderately high to high risk factors in 52 RAIs that should have been clearly included on FCAPs. For 59 of the 247 high risk factors identified on the RAIs, no FCAPs were prepared to address the risks. For the remaining 188 high risk factors where FCAPs were prepared, we found that:

- 149 high risk factors identified on the RAIs were not clearly included on the FCAPs.
- 39 high risk factors identified on the RAIs were clearly included on the FCAPs.

The Department stated that social workers and families prioritize the high risk factors that create the greatest need for a child and family and that certain high risk factors cannot be changed with interventions. For this reason, high risk factors identified on the RAI may not always be included on the FCAP. However, this prioritization of high risks is not in accordance with the Model which states that the risk factors identified for inclusion on the FCAP will be those given the highest rating on the RAI.

The Department limits its ability to effectively address the risk of future maltreatment of children when the highest risks identified on the RAIs are not clearly included on the FCAPs.

**Finding**

13. The highest risks of future maltreatment of children identified in Risk Assessment Instruments were not always clearly included on Family Centered Action Plans, as required by the Risk Management Decision Making Model.

**FCAP Activities Not Clearly Linked to Risks**

There was no clear link between risk factors identified and included on FCAPs and the activities listed on FCAPs. We examined 18 FCAPs that clearly included 39 high risk factors identified in RAIs. We were unable to determine whether there were activities listed on the FCAPs to address 37 of the 39 high risk factors.

The Department limits its ability to effectively address the risk of future maltreatment of children when risks identified and included on FCAPs are not clearly linked to FCAP activities designed to reduce those risks.

**Finding**

14. Risks identified and included on Family Centered Action Plans were not clearly linked to Family Centered Action Plan activities designed to reduce those risks.

**FCAP Activities Not Measureable and Completion Dates Not Recorded**

We examined the 49 FCAPs in our sample that were prepared during the audit period and found that the majority of activities listed on the FCAPs were not measureable and there were instances where activity completion dates were either not specified or specified as ongoing. Examples of non-measureable activities that we identified on FCAPs included:

- parents will use simple terms to explain expectations of child.
- parents will comply with any further recommendations by the Department.
- parents will be consistent with discipline and expectations of child.
- parents will continue to work co-operatively with their social worker.

As a result, we could not determine whether FCAP activities were achieved and risks were reduced.

**Finding**

15. The majority of activities listed on Family Centered Action Plans in our sample were not measureable and we could not determine whether these activities were achieved and risks were reduced.

### 2D. Frequency of Visits to the Family Home

**Introduction**

An important element in managing family progress and the safety and well-being of children are face-to-face visits between the social worker, children and parents in the family home. Visits to the family home allow social workers to:

- observe parent-child interaction and conduct interviews to determine whether children are receiving appropriate care;
- develop the relationships that are necessary to affect the changes that are required to protect children; and
- update risk and monitor FCAP progress.

The Model does not specify how often social workers should visit the family home. Visits to the family home to assess case progress and child safety are at the discretion of the social worker. Social workers document their visits to the family home in notes in CRMS.

Similar to the Department's requirement that higher risk family homes have more frequent case file reviews, social worker visits to the family home to monitor FCAP activity and assess child safety should occur more frequently for higher risk homes. We examined 50 PIP case files and found that visits to the family home were not based on risk and multiple social workers completed visits to the same family homes.

**Visits to the Family Home Not Based on Risk**

In most of the 50 files examined, there was no correlation between the assessed risk of future maltreatment of children in the family home and the frequency of social worker visits to the family home. For example, we identified numerous instances where lower risk family homes were visited more frequently than higher risk family homes. In 2 of 20 files where overall risk was assessed at high or moderately high for a period of nine months or more, the social worker visited the family home once in two years; however, in 2 of 12 files examined where overall risk was assessed at low or moderately low for a period of nine months or more, the social worker visited the family home 12 times in one year and seven times in 15 months.

The Department stated that it will be establishing a minimum contact standard for families based on assessed risk when it implements a new Structured Decision Making Model in 2017.

**Finding**

16. Some family homes which were assessed by social workers as having a higher risk of future maltreatment of children were visited less frequently than lower risk family homes.

**Multiple Social Workers Involved in Same Case Files**

In 14 of the 50 files examined, we found that three or more different social workers had completed visits to the same family home during the audit period. In two cases, five different social workers had visited the family home during the audit period. As the number of social workers visiting the family home increases, there is increased risk that working relationships and case file progress may be adversely affected.

**Finding**

17. Multiple social workers made visits to the same family home during the audit period, which increases the risk that working relationships and case file progress may be adversely affected.

## 2E. Documentation of Family Centered Action Plan Progress

### Introduction

The Model states that the FCAP serves as a benchmark for measuring client progress in reducing risks to children in the family home and requires careful monitoring and review by a social worker to ensure it is meeting the needs of the family while focusing on reducing the risks identified on the RAI. Once every six or nine months during case file review, a social worker must reassess risk and determine whether the required FCAP activities were completed and objectives were achieved. The social worker determines this through analysis of information obtained from:

- observations and interviews with parents and children carried out in connection with the case file review;
- observations and interviews with parents and children carried out during the review period; and
- discussion with collaterals (counsellors, physicians, teachers) during the review period.

Information obtained by a social worker through visits with parents and children and discussion with collaterals are normally documented in notes in CRMS.

We examined 50 PIP case files and found issues with social worker documentation of FCAP monitoring activities.

### FCAP Progress Not Clearly Documented

In 24 of the 50 files examined, 49 FCAPs were prepared that identified 282 activities requiring completion to reduce risks. If the FCAP did not identify whether activities were completed, we had to read a significant volume of notes in CRMS to determine whether the activities were completed. We found that, for 94% of the FCAP activities, we were unable to determine from the FCAPs or the notes in CRMS whether the activities were completed.

The Department stated that information regarding FCAP activity completion will be more accessible when it implements a new Structured Decision Making Model in 2017.

**Finding**

18. Social workers did not always clearly document whether Family Centered Action Plan activities, which are intended to reduce risks to children, were completed.

**Visits to the Family Home Not Documented in a Timely Manner**

In 26 of 50 files examined, there were instances where a social worker did not document the results of their visit to the family home in CRMS in a timely manner. CRMS documentation delays averaged nine months and ranged from a high of 29 months to a low of one month. Documentation delays increase the risk that vital case file information obtained during family visits will be unavailable or lost.

## Finding

19. Social workers did not always document the results of visits to family homes in a timely manner.

## 3. Kinship Services Program

**Objective**

To determine whether the Department delivers Kinship Services in accordance with its policies and procedures.

### Conclusion

The Department of Children, Seniors and Social Development does not always deliver Kinship Services in accordance with its policies and procedures.

**Overview**

A child in PIP may be placed with relatives or significant others (kinship caregivers) when an assessment of safety factors indicates it is necessary for the child to live temporarily away from their parents. A social worker enters into a voluntary and collaborative arrangement with the child's parents and kinship caregivers which allows the parents to retain legal custody and transfer care of the child to kinship caregivers. Children may be reunified with their parents when risk has been reduced to a level that is determined to be safe for children. If children cannot be reunified with their parents, then an alternate permanency plan must be explored (i.e. adoption, kinship services with legal custody or a long-term kinship arrangement).

On October 1, 2013, the Kinship Services Program replaced the Child Welfare Allowance (CWA) Program. Under the new program, policies and procedures were developed to:

- expand the eligibility criteria for caregivers;
- enhance the caregiver home assessment process;
- establish a formalized kinship care agreement;
- establish a planning and monitoring policy with a focus on permanency; and
- increase funding to kinship caregivers.

As at March 31, 2015, there were 504 children residing in kinship homes throughout the Province. Financial support paid under the Kinship Services Program totaled approximately $6.6 million during 2014-15 or $13,000 per child.

We assessed the Department's performance against the following criteria:

A. The Department delivers Kinship Services in accordance with the Protection and In-Care Policy and Procedure Manual.

## 3A. Compliance with Kinship Services Policies and Procedures

### Introduction

The Protection and In-Care Policy and Procedure Manual (the Manual) requires that social workers complete a Kinship Home Assessment (KHA) Form to determine whether specific conditions exist to protect the safety and well-being of children before they are placed in kinship caregiver homes. Specifically, the social worker must:

- conduct an in-person interview with the child to determine the child's wishes and relationship with the proposed kinship caregivers;

- conduct an in-person interview with the proposed kinship caregivers to determine their understanding, commitment and role in the kinship living arrangement;

- carry out a visit to the proposed caregivers home to determine whether there is suitable physical space, living and sleeping arrangements;

- obtain from all people living in the proposed kinship home who are over the age of 18, a signed Self-Declaration and Consent Form and Departmental Records Check Form. These forms require individuals to disclose whether they have been convicted of a criminal offense, have a criminal record or have been involved with child protection in the past. The forms also allow the social worker to carry out a verbal police check, provincial court check and departmental records check; and

- obtain the results of a criminal records check for all people living in the proposed kinship home who are over the age of 12, including the results of a vulnerable sector check for all people over the age of 18. A vulnerable sector check is conducted to identify a person who has been pardoned for a sexual offense.

Before a child can be placed with kinship caregivers, a KHA Form must be approved by a supervisor or manager and a Kinship Care Agreement (KCA) must be signed by all parties. The KCA must be reviewed within the first three months to ensure any outstanding documentation has been obtained and that an FCAP is in place outlining the activities being taken to reunify the child with their parents. A KCA review must occur every six months following the initial three month review. During each KCA review, a social worker must have at least one in-person contact with the child and kinship caregivers and update the permanency plan for the child.

We examined a random sample of 36 kinship case files to determine whether social workers completed KHAs, entered into KCAs with parents and kinship caregivers and monitored children and kinship caregivers in accordance with the Manual during the audit period. We identified non-compliance issues in the areas of kinship caregiver home assessment, approval and monitoring. As well, we identified an issue with the level of support and monitoring provided to children in the program.

**KHAs Not Completed and Approved**

We examined 12 kinship files assessed and approved on or after October 1, 2013 under the new Kinship Services Program. In one of the files examined, a child was placed with three different kinship homes during the audit period; therefore, we examined the assessment and approval of 14 kinship homes for compliance with the Manual.

We found the following:

- In 3 of the 14 KHAs examined, there was no Self Declaration and Consent Form completed by people living in the caregiver home.
- In 6 of the 14 KHAs examined, a social worker did not complete a verbal police check on people living in the caregiver home prior to placing a child with the caregiver.
- In 6 of the 14 KHAs examined, a social worker did not complete a provincial court check on people living in the caregiver home prior to placing a child with the caregiver.
- In 5 of the 14 KHAs examined, a social worker did not obtain a criminal record check from the police for people living in the caregiver home.
- In 5 of the 14 KHAs examined, a social worker did not obtain the results of a vulnerable sector check from the police for people living in the caregiver home.
- In 3 of the 14 kinship homes, a person in the kinship home had a criminal record and a regional manager did not approve the KHA as required.
- In 3 of the 14 kinship homes, a person in the kinship home was previously a client with child protection services of the Province and a regional manager did not approve the KHA as required.
- In 8 of the 14 KHAs examined, a child was placed with kinship caregivers prior to completion and approval of the KHA and KCA. In 6 of the 8 cases, the Department stated that the child was living with the caregiver under a protection investigation safety plan prior to the KHA. However, we found that the Department had no policies and procedures to address the safety of children living in out-of-home living arrangements under a safety plan. Policies and procedures were subsequently established in December 2015.
- In 1 of the 14 KHAs examined, a KHA Form was not completed.

When social workers do not complete and managers do not approve KHAs in accordance with the Manual, there is an increased risk that children are placed in kinship homes that are not safe and supportive.

## Findings

20. Social workers did not always complete Kinship Home Assessments in accordance with the Protection and In-Care Policy and Procedure Manual to determine whether kinship homes were safe and supportive for children.

21. Regional managers did not always approve Kinship Home Assessments when children were placed in kinship homes with people with criminal records.

22. Regional managers did not always approve Kinship Home Assessments when children were placed in kinship homes with people that were previously clients with child protection services of the Province.

**Home Assessments Not Completed Under the CWA Program**

Prior to October 1, 2013, assessment policy and procedures for a caregiver home included:

- a home visit and assessment of physical space;
- personal contact with the relatives or significant others;
- a determination of the relative or significant others commitment and understanding of the need for child protection; and
- departmental and police records checks of adults in the caregiver home.

As part of our examination of home assessments conducted under the CWA Program, we examined 25 case files assessed and approved prior to October 1, 2013 and found the following:

- In 15 of the 25 CWA assessments examined, there was no evidence that a social worker completed a home visit to assess the caregiver home.
- In 11 of the 25 CWA assessments examined, there was no evidence that a social worker completed an interview with the caregivers to determine their commitment and understanding of child protection.
- In 20 of the 25 CWA assessments examined, there was no evidence that a social worker obtained written confirmation from the police whether the caregivers or other people living in the caregivers' home had police records.
- In 16 of the 25 CWA assessments examined, there was no evidence that a social worker completed a departmental records check.

The Department did not provide evidence that social workers completed caregiver home assessments as required and we could not determine whether children were placed in safe and supportive homes under the CWA program.

**Finding**

23. The Department of Children, Seniors and Social Development did not always provide evidence that social workers completed home assessments to determine whether caregiver homes approved under the Child Welfare Allowance Program were safe and supportive for children.

**Vulnerable Sector Checks Not Required Under the CWA Program**

On October 1, 2013, there were 482 children living with caregivers that had been assessed and approved under the CWA program; however, these homes were not reassessed after implementing the more rigorous KHA procedures under the Kinship Services Program. One deficiency with the CWA home assessment process was the lack of a requirement that a social worker obtain vulnerable sector checks for all people living in the caregiver home 18 years of age or older.

The Department did not reassess CWA homes under the enhanced kinship home assessment process and therefore may not know whether all of the 482 children in these homes were safe.

**Findings**

24. The Department of Children, Seniors and Social Development did not reassess caregiver homes approved under the Child Welfare Allowance Program when it implemented an enhanced kinship home assessment process on October 1, 2013.

25. The Department of Children, Seniors and Social Development may not know whether children living in caregiver homes approved under the Child Welfare Allowance Program are safe because it did not require a vulnerable sector check for people 18 years of age or older who were living in these homes.

**Children Placed in Kinship Homes When Criminal Record and Vulnerable Sector Checks Not Obtained**

Department policy requires that people living in the kinship home make applications with the police for criminal records and vulnerable sector checks and that these record checks must be received by the Department within 90 days of child placement.

In one of the files examined, a child had been placed with relatives approved as kinship caregivers in December 2014 and criminal record and vulnerable sector check documentation had not yet been obtained from the police. In March 2015, the Department discovered that one of the caregivers had refused to make an application with the police for a vulnerable sector check and immediately removed the child from the kinship home, as the caregiver did not comply with the kinship home screening and assessment process. As a result, this child was at risk in the kinship home during the period December 2014 to March 2015. The Department's current kinship home assessment process does not address this risk to children.

Children in kinship homes are at risk when criminal record and vulnerable sector check documentation are not obtained from the police prior to placement.

## Finding

26. Department of Children, Seniors and Social Development policy allows children to be placed in kinship homes prior to the receipt of criminal record and vulnerable sector check documentation from the police for people living in the kinship home.

**KHA Form Inadequate**

The KHA Form is intended to capture the information required to determine whether a kinship home is suitable to care for children. Supervisors and managers review and approve kinship homes based on the information documented by social workers in the KHA Form. Therefore, it is important that social workers document key information such as whether Self-Declaration and Consent Forms and the results of criminal record, vulnerable sector, and provincial court checks were obtained for people living in the kinship home.

We found that the KHA Forms completed in our sample did not document the number and identity of all people living in the kinship homes. As a result, we could not determine whether the social worker's assessment of Self-Declaration and Consent Forms, criminal record, vulnerable sector, and provincial court checks, was complete for people living in the kinship homes. Consequently, supervisors and regional managers may not readily know whether kinship homes are suitable for children.

## Finding

27. Supervisors and regional managers approve kinship homes when key information is not documented on the Kinship Home Assessment Form.

**Parents Not Assessed for Payment of Financial Support**

The *Family Law Act* requires that parents financially support their children. The Department requires that social workers assess whether the parents of children in kinship living arrangements are able to pay the cost of care of their children. Where parents are able to provide financial support, this support is deducted from the financial assistance provided to the kinship caregivers by the Department.

In 35 of the 36 kinship files that we examined, there was no evidence that social workers verified the income of parents or completed an assessment of the parents' ability to financially support their child in the kinship living arrangement.

The Department limits its ability to know whether parents are able to contribute to the costs of care of their children when social workers do not assess parents' financial ability to provide support.

## Finding

28. Social workers did not assess whether parents were able to financially support their children in kinship living arrangements in 35 of the 36 kinship files we examined, as required by the Protection and In-Care Policy and Procedure Manual.

**Kinship Care Agreements Not Completed and Reviewed**

The Department requires that social workers plan for and monitor the children in kinship homes to ensure that the needs of children are being addressed and that they live in safe and supportive environments. The planning for and monitoring of children is documented on a KCA within the first three months of placement and, at a minimum, once every six months thereafter when the KCAs are reviewed and updated. As part of their KCA review, a social worker must:

- conduct a private interview with the child;
- meet with the kinship caregivers;
- assess the type and frequency of social worker contact with the child and kinship caregivers; and
- update the permanency plan for the child.

We examined 36 kinship services files to determine whether social workers were completing and reviewing KCAs as required. We found the following:

- In 5 of the 36 kinship files examined, no KCA reviews were completed.

- Where KCA reviews were completed, the reviews were completed late 47% of the time. The number of days that the KCA reviews were late averaged 114 days and ranged from a high of 720 days to a low of 15 days.

- In 4 of the 64 KCA reviews completed during the audit period, the supervisor did not approve the KCA review.

- In 60 of the 64 KCA reviews completed during the audit period, a social worker did not document that they assessed whether additional contact with the child and caregiver was necessary.

When social workers do not prepare or review KCAs as required by the Manual, there is an increased risk that the needs of children will not be addressed and that children are in kinship homes that are not safe and supportive.

## Finding

29. Social workers did not always prepare and review Kinship Care Agreements to document whether children's needs were addressed and that they were in safe and supportive kinship homes.

**Children in Kinship Homes Receive Less Support and Monitoring than Children in Relative Foster Homes**

Children living in relative foster homes under the care of the Department and children living in kinship homes under the care of caregivers are in living arrangements with relatives outside of the family home because they were determined to be unsafe living with their parents. The only substantive difference in these two living arrangements is that the Department has legal responsibility for children in relative foster homes. Nevertheless, children living in kinship homes receive less departmental financial support and monitoring than children living in relative foster homes.

**Table 4**

**Child Protection Services**
**Approximate Annual Financial Support and Monitoring of Children in Kinship and Relative Foster Homes**
**As at March 31, 2015**

| | Kinship Home | Relative Foster Home |
|---|---|---|
| Number of Children | 504 | 291 |
| Approximate Annual Financial Support | $13,000 per child | $30,000 per child* |
| Social Worker Visits to Child and Caregiver Home | Once every six months | Once a month |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Children, Seniors and Social Development (unaudited).
* Relative foster home must complete training, otherwise amount is approximately $23,000

The Department can provide more than double the level of financial support to children in relative foster homes. As well, the Department visits children in relative foster homes six times more often than children in kinship homes, even though the children in both programs are in the same or similar living arrangements.

We also found that relative foster homes can receive an additional $7,000 per year when the foster parents choose to complete a 21 hour training course, which is not mandatory.

## Findings

30. Children living in kinship homes receive less financial support than children living in relative foster homes when the only substantive difference in their living arrangements is that the Department of Children, Seniors and Social Development has legal responsibility for children in relative foster homes.

31. Financial support provided to relative foster homes is increased by $7,000 per year when the foster parents choose to complete a 21 hour training course, which is not mandatory.

32. Children living in kinship homes receive less monitoring by social workers than children living in relative foster homes when the only substantive difference in their living arrangements is that the Department of Children, Seniors and Social Development has legal responsibility for children in relative foster homes.

## 4. In-Care Program

**Objective**

To determine whether the Department complies with its policies and procedures to effectively manage the safety, well-being and development of children in the In-Care Program.

### Conclusion

The Department of Children, Seniors and Social Development does not always comply with its policies and procedures to effectively manage the safety, well-being and development of children in the In-Care Program.

**Overview**

Children are placed in the In-Care Program when a less intrusive course of action to protect a child is not available. Under the In-Care Program, the Department normally removes a child from the family home under court warrant and places the child in a foster, staffed residential or other home. The Department has interim care of children following removal from the family home until there are court hearings to hear evidence and review the Department's plan for the child. These court hearings are required to be held within 30 days of the child's removal. As a result of court hearings, a judge may order that the child be:

- returned to their parents;
- returned to their parents under the supervision of the Department pending further court hearings;
- placed in the care or temporary custody of a relative or significant other, under the supervision of the Department pending further court hearings;
- placed in the interim custody of the Department pending further court hearings;
- placed in the temporary custody of the Department pending further court hearings; or
- placed in the continuous custody of the Department until the age of 18.

The planning for and monitoring of children in the care or custody of the Department is the responsibility of the social worker. The social worker documents and monitors the plan for the child using an In-Care Progress Report (IPR) which must be reviewed and updated every six months. In accordance with the Manual, IPR planning must:

- be consistent with the plan for the child submitted to the court;
- address permanency for the child;

- identify supports and services for the child; and
- meet the needs of the child.

Children under the care or custody of the Department may only be placed with resources that have been assessed and approved by the Department. Placement resources are monitored by social workers to determine whether children's needs are being met and that they are living in environments that are safe and supportive.

Table 5 shows the number of children In-Care by level of care and placement resource and the approximate annual and average cost per child, for the year ended March 31, 2015.

**Table 5**

**Child Protection Services**
**Number and Cost of Children In-Care by Level of Care and Placement Resource**
**As at March 31, 2015**

| Level of Care | Placement Resource Type | Number Children | Annual Cost | Average Per Child |
|---|---|---|---|---|
| Level 1 | Relative Foster Home | 206 | $4.8 million | 23,000 |
| | Regular Foster Home | 30 | .69 million | 23,000 |
| Level 2 | Relative Foster Home | 85 | 2.55 million | 30,000 |
| | Regular Foster Home | 440 | 14.65 million | 33,000 |
| Level 3 | Specialized Foster Home | 13 | .47 million | 36,000 |
| Level 4 | Staffed Residential Home | 113 | 27.2 million | 241,000 |
| Other | Group Homes (Labrador) | 8 | 2.49 million | 312,000 |
| Other | Out of Province | 32 | 7.4 million | 231,000 |
| Other | ALA, Therapeutic Foster Home | 17 | 2.4 million | 141,000 |
| Other | Other | 11 | .25 million | 23,000 |
| **Total** | | **955** | **$62.9 million** | **$65,900** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Children, Seniors and Social Development (unaudited).

The annual cost of caring for 955 children in In-Care as at March 31, 2015 was $62.9 million, or $65,900 per child.

We assessed the Department's performance against the following criteria:

A. Children in the care or custody of the Department are placed with placement resources in accordance with the Department's policies and procedures.

B. Goals and tasks listed in the In-Care Progress Report work plan are clearly linked to the identified needs of children.

C. The In-Care Progress Report work plan specifically addresses permanency planning for children in the care or custody of the Department.

D. The In-Care Progress Report is prepared, reviewed and updated in accordance with the Department's policies and procedures.

E. The frequency of visits to children In-Care and their placement resources is in accordance with the Department's policies and procedures.

F. The results of social worker visits to children In-Care and their placement resources are documented and clearly indicate whether In-Care Progress Report work plan activities are being achieved and the identified service needs of children are being met.

G. Annual reviews of placement resources are conducted in accordance with the Department's policies and procedures.

## 4A. Placement of Children In-Care

### Introduction

The Manual requires that every effort be made to match a child In-Care with a placement resource that can provide protection and meet their emotional and developmental needs. Relatives or significant others are normally considered as the first placement option. The needs of children placed In-Care are required to be documented and addressed in an IPR within six months of their removal from the family home.

A social worker must provide the placement resource with a placement card and other information about the child on the day of placement. If an IPR is completed, then a social worker must provide the placement resource with a copy of the IPR work plan. Within three days following removal from the family home, a social worker must ensure the child is medically examined. Within seven days of placement, a social worker must meet with the child to discuss the reasons for the placement and the plan for the child.

We examined a sample of 40 In-Care case files to determine whether social workers placed children with placement resources in accordance with the Manual. We found instances where social workers did not comply with the Manual.

### Social Workers Did Not Always Comply with Placement Procedures

In 7 of the 40 files examined, there was insufficient information available in the file regarding placement. In the remaining 33 files examined, there were 37 placements during the audit period.

We found the following:

- In 24 of the 37 placements, there was no evidence that the social worker provided the placement resource with a placement card.

- In 9 of the 37 placements, an IPR was completed prior to the date of placement; however, there was no evidence that the IPR work plan was provided to the placement resource.

- In 5 of the 37 placements, there was no evidence that the social worker met with the child within the first seven days of placement.

Furthermore, in 21 of the 40 files examined, there was no Placement Medical Form to evidence that a medical examination was completed when a child came into the care of the Department.

The ability of placement resources to meet the needs of children placed in their care is diminished when they are not provided with important information about children.

**Finding**

33. Social workers did not always comply with the Protection and In-Care Policy and Procedure Manual when placing children with placement resources.

### 4B. In-Care Progress Report Work Plans and Child Needs

**Introduction**

The identified needs of children In-Care are documented in various service need categories on the IPR. Social workers must then address these service needs by establishing goals and tasks in the IPR. Examples of service need categories included on the IPR are child health, education, emotional and behavioral development, relationships with family and personal skills development. An IPR includes a work plan that specifies:

- goals that address service needs;
- tasks required to achieve the service need goals;
- the people responsible for completing the tasks; and
- target dates for completing tasks and the dates tasks were completed.

An IPR is required to be reviewed and updated every six months.

We examined a sample of 40 In-Care case files to determine whether goals and tasks on the IPR work plans were clearly linked to the service needs of children. We found instances where social workers either did not complete IPRs or did not complete IPRs in accordance with the Manual.

**IPRs Not Completed**

In 12 of the 40 files examined, no IPR was completed during the audit period as required. As a result, there were no work plans to address the service needs of these children.

**Finding**

34. In-Care Progress Reports were not always completed to address the service needs of children In-Care, as required by the Protection and In-Care Policy and Procedure Manual.

**IPR Work Plans Did Not Address Child Needs**

In 28 of the 40 files examined, we reviewed 55 IPR work plans completed during the audit period. We found that goals and tasks were linked to the needs of children, however the goals and tasks would be difficult to monitor because:

- In all 55 work plans completed, some or all of the goals and tasks on the work plans were not measurable. Examples of non-measureable tasks that we identified on IPR work plans included:
    - child will have their needs for security, safety and emotional support met.
    - child will continue to be monitored and treated for conditions she has.
    - take to doctor as needed.
    - register child for programs.
- In 47 of the 55 work plans completed, target dates were not established for some or all of the goals and tasks on the work plans.

The goals and tasks established to address the service needs of children In-Care were not always measureable and the timeframes for completion were not always established. As a result, the Department limits its ability to determine whether the needs of children are being addressed.

**Finding**

35. In-Care Progress Report goals and tasks were clearly linked to the identified needs of children in our sample, however most goals and tasks were not measureable and the timeframes for completion were not always established.

### 4C. In-Care Progress Reports and Permanency Planning

**Introduction**

The Manual states that "*permanency planning for the child/youth is paramount*". The IPR is the primary tool for monitoring case planning, progress and outcomes and should therefore specifically address permanency planning.

The Manual defines "*permanent*" as being enduring, lasting or stable. The permanency plan for most children coming into the care or custody of the Department is reunification with their parents. If reunification with parents is not possible, the Department will make an application to the court for continuous custody of the child and explore an alternate permanency plan such as adoption, transfer of custody, continuation of the child's existing placement or independent living.

The *Act* states that all decisions regarding children in need of protective intervention should consider "*the importance of stability and permanency in the context of the child or youth's care.*" The *Act* imposes timelines for court proceedings and limits the number and length of temporary custody orders that may be issued to achieve family reunification. These timelines are in place to facilitate timely permanency planning for children. The *Act* states that:

- a social worker or manager must file an application with the court for a protective intervention hearing to be held no later than 30 days following a child's removal. During a court hearing, a judge may determine whether a child is in need of protective intervention and whether an order should be issued awarding interim, temporary or continuous custody of children to the Department;

- a judge may issue a six month temporary custody order when the Department's plan for the child is reunification with the parents. The *Act* only permits a total of two temporary custody orders in a child's life unless there are exceptional circumstances. The second temporary custody order may be issued for three months if the child is less than six years of age, or for six months if the child is six years of age or older; and

- the court may adjourn a proceeding under the *Act* one or more times for a total of three months.

When the timeframes specified in the *Act* have expired, a judge must order that the child either be placed in the continuous custody of the Department, be placed in the custody of a person other than the parents, or be returned to their parents. If a judge orders that a child be placed in the continuous custody of the Department, all parental rights are severed and an alternate permanency plan is developed.

We examined a sample of 40 In-Care case files to determine whether the IPR addressed permanency planning. Although the IPRs addressed permanency planning, we found issues relating to the timeframe to permanency, the movement of children between placement resources and social worker turnover within case files.

**Time to Permanency Exceeds Established Legislated Timeframes**

The Manual does not specify a timeframe by which it expects children to reach permanency. Provided the timeframes specified in the legislation are followed, children in the care or custody of the Department could normally expect to be placed in a permanent living arrangement (i.e. reunited with parents, continuous custody, in the custody of another) within 13 to 16 months, depending on the age of the child, following removal from their parents' home. For the purpose

of our examination, we used a timeframe of 18 months to assess timeliness to permanent placement. We found the following:

- In 6 of the 40 files examined, a child was in the interim care, interim custody or temporary custody of the Department for a period of less than 18 months.

- In 10 of the 40 files examined, a child was placed in the continuous custody of the Department within the legislated timeframes.

- In 24 of the 40 files examined, a child was in the interim care, interim custody or temporary custody of the Department for a period of time that exceeded 18 months. The number of months that the children were in interim care, interim custody or temporary custody averaged 29 months and ranged from a high of 48 months to a low of 18 months.

Permanency for children In-Care is diminished when their custody status is not determined within established legislated timeframes.

## Findings

36. The Department of Children, Seniors and Social Development has not established time to permanency expectations for children In-Care.

37. A significant number of children in our sample had been in the interim care, interim custody or temporary custody of the Department of Children, Seniors and Social Development for a period of time that exceeded established legislated timeframes.

**Number of Placements and Social Worker Turnover**

Children in the care or custody of the Department require stability in their living arrangements prior to reaching permanency. The more a child is moved from placement resource to placement resource and the more social workers assigned to a child change, the more likely it is that a child's well-being and development will not be supported. We found the following:

- In 5 of the 40 files examined, a child was placed with 3 or more placement resources while in the interim care, interim custody or temporary custody of the Department. In 3 of the 5 files examined, a child was placed with:

    - six different placement resources over a period of 14 months;

    - six different placement resources over a period of 21 months; and

    - eight different placement resources over a period of 24 months.

- In 16 of the 40 files examined, there were three or more social workers assigned to the case file during the audit period. In 8 of these 16 files, there were five or more social workers assigned to the case file during the audit period.

When children are moved from placement resource to placement resource and there is significant social worker turnover in the case file, there is an increased risk that the children's well-being and development will not be supported.

**Finding**

38. Some children in the interim care, interim custody or temporary custody of the Department of Children, Seniors and Social Development had been placed with numerous placement resources and had numerous social workers assigned to their file, which increases the risk that the children's well-being and development will not be supported.

## 4D. IPR Preparation, Review and Approval

### Introduction

The Department requires that social workers complete an IPR within six months of a child entering the care of the Department and every six months thereafter while a child is In-Care. Supervisors must review and approve the IPR.

To assess compliance, we examined 40 In-Care case files to determine whether social workers prepared and supervisors approved IPRs in accordance with the Manual during the audit period. We identified non-compliance in the areas of IPR preparation and approval.

### IPRs Not Completed as Required

In 7 of the 40 files examined, no IPRs were ever completed. In the remaining 33 files examined we found the following:

- In 5 of the 33 files examined, an IPR was not completed during the audit period.

- In 21 of the 33 files examined, an IPR was not prepared within six months of the child entering In-Care; or, if the child was already In-Care, within six months of the Department implementing the IPR requirement on June 30, 2011. The number of days late averaged 368 days and ranged from a high of 1,162 days and a low of 15 days.

- In 27 of the 33 files examined, we examined 60 IPRs and found that 49 IPRs were not completed within six months of the previous IPR. The number of days late averaged 128 days and ranged from a high of 844 days and a low of one day.

The Department limits its ability to meet the needs of children In-Care when social workers do not complete IPRs as required.

## Findings

39. In-Care Progress Reports were not always prepared within six months of a child entering In-Care. For our sample, the number of days late averaged 368 days.

40. In-Care Progress Reports were not always prepared every six months while a child was In-Care. For our sample, the number of days late averaged 128 days.

## 4E. Frequency of Visits to Children and their Placement Resource

### Introduction

The Manual requires that a social worker have at least one in-person contact per month with:

- each child in the care or custody of the Department to review and discuss, where appropriate, the IPR and work plan progress and either:
  - the foster parents where a child is residing to monitor the child's progress and review the supports and services in place, and to discuss, observe and assess the foster parents relationship with the child; or
  - the staffed residential home where a child is residing to meet with the staff, and assess the quality of care provided.

Our examination of 40 case files identified non-compliance with the level of social worker in-person contact.

### Children and Placement Resources Not Visited As Required

Social workers are required to document the results of their monthly visits in a note in CRMS. This type of data is narrative in format and is not designed to monitor the number and frequency of social worker visits. Therefore, in order to determine compliance with the required level of social worker in-person contact with children and placement resources, we had to read a significant volume of notes in CRMS.

We examined 40 case files and found that in one of the files, there were no CRMS notes. In the remaining 39 files we found the following:

- In 34 files, a social worker did not visit with the child every month as required.
- In 2 files, a social worker did not visit with the child at all.
- In 38 files, a social worker did not visit with the placement resource every month as required.

- In 1 file, a social worker did not visit with the placement resource at all.

- In 30 files, there were significant delays between the social worker visits and documentation in CRMS. CRMS input delays averaged 14 months and ranged from a high of 36 months to a low of 1.5 months.

The Department limits its ability to determine whether children are making progress under IPR work plans when social workers do not visit children and placement resources as required. Furthermore, CRMS input delays increase the risk that vital information obtained during family visits may be unavailable or lost.

## Findings

41. The Department of Children, Seniors and Social Development does not have systems in place to readily determine and monitor the level of social worker in-person contact with children and placement resources.

42. Social workers did not always visit children and their placement resources every month to review and assess child progress, as required by the Protection and In-Care Policy and Procedure Manual.

43. There were significant delays between social worker visits and documentation of those visits in CRMS.

## 4F. Documentation of IPR Work Plan Progress

### Introduction

The Manual requires that social workers monitor children and their placement resources to determine whether the goals and tasks listed on the IPR work plan are being achieved and the service needs of children are being met. Monitoring activities include visits to children and their placement resource and meetings with the In-Care Planning Team and other collaterals. A social worker must also hold a case conference with the child's In-Care Planning Team which may include one or more of the child, parents, foster parents, teachers, counsellors, etc.

Information obtained by a social worker during monitoring visits and meetings are documented in notes in CRMS. The IPR work plan requires that the social worker record the date that the IPR tasks were completed.

### IPR Work Plan Progress Not Always Documented

We examined 40 case files and found the following for the audit period:

- In 12 of the 40 files examined, no IPRs were completed as required. For the remaining 28 files examined, social workers completed 55 IPR work plans.

- In 49 of the 55 IPR work plans, we were unable to determine from the work plan whether tasks were completed.
- In 23 of the 55 IPRs work plans, there was no evidence that a case conference was held with the In-Care Planning Team as required.

When social workers do not document whether work plan tasks were completed and do not conduct case conferences with the In-Care Planning Team, the Department limits its ability to determine whether IPR work plan goals are achieved and children are making progress.

**Findings**

44. Social workers did not always document whether In-Care Progress Report work plan tasks were achieved and goals were met, as required by the Protection and In-Care Policy and Procedure Manual.

45. Social workers did not always conduct case conferences with the In-Care Planning Team, as required by the Protection and In-Care Policy and Procedure Manual.

## 4G. Annual Review of Placement Resources

### Introduction

The Manual requires that social workers carry out an annual review of regular and specialized foster homes to determine whether these homes continue to meet the Department's approval requirements. In connection with the annual review, the social worker must:

- complete an interview with all people residing in the foster home;
- complete a Foster Home Safety Checklist;
- obtain a Declaration of Confidentiality from the foster family; and
- complete a written review of whether the foster family is meeting the required competencies relevant to their level of approval.

All annual reviews must be reviewed and approved by a supervisor. Every five years, the social worker must obtain an updated criminal records check and departmental records check for every person residing in the foster home that is 12 years of age or older.

### Annual Reviews Not Completed or Completed Late

In 20 of the 40 files examined, a child was living in a regular foster home placement as at March 31, 2015 and an annual review of the foster home was required.

In 1 of the 20 foster home files examined, there were no annual reviews of the foster home during the audit period.

In the remaining 19 foster home files examined, there were 21 annual reviews carried out during the two year period ended March 31, 2015 and 15 annual reviews carried out immediately following the two year period, for a total of 36 annual reviews. We found the following:

- 28 of the 36 annual reviews were not completed within a year of the foster home approval or the previous annual review. The number of days that annual reviews were late averaged 254 days and ranged from a high of 1,881 days to a low of four days.

- In 5 of the 21 annual reviews completed during the two year period, the Foster Home Safety Checklist was not reviewed and updated.

- In 5 of the 21 annual reviews completed during the two year period, a Declaration of Confidentiality was not signed by the foster family.

- In 3 of the 21 annual reviews completed during the two year period, a supervisor did not review and approve the annual review.

- In 6 of the 20 regular foster homes where a child resided as at March 31, 2015, the foster home either did not have a criminal record check completed or the criminal record check was more than five years old.

When social workers do not carry out annual reviews of regular foster homes, the Department limits its ability to determine whether these foster homes continue to meet approval requirements.

Furthermore, while the Department requires that people residing in regular foster homes complete a criminal records check every five years, the Department does not require that a vulnerable sector check be completed every five years.

## Findings

46. Social workers did not always complete annual reviews of regular foster homes to determine whether they continue to meet the approval requirements of the Department of Children, Seniors and Social Development. When annual reviews were completed in our sample, the majority were completed late by an average of 254 days.

47. While the Department of Children, Seniors and Social Development requires that people residing in regular foster homes complete a criminal records check every five years, the Department does not require that a vulnerable sector check be completed every five years.

**No Annual Review Requirement for Relative Foster Homes**

The Manual does not require social workers to carry out annual reviews of relative foster homes. In 16 of the 40 files examined, a child was in a relative foster home as at March 31, 2015.

Consequently, the Department did not reassess the suitability of these homes. For example, there was no requirement that criminal record and vulnerable sector checks be updated for persons living in these homes.

**Finding**

48. Relative foster homes are not subject to an annual review to determine whether they continue to meet the Department of Children, Seniors and Social Development's approval requirements.

## 5. Governance

**Objective**

To determine whether the Department effectively assesses the quality of its child protection programs.

### Conclusion

The Department of Children, Seniors and Social Development does not effectively assess the quality of its child protection programs.

**Overview**

In July 2011, the Department announced it was establishing a Quality Assurance Division (the Division) to improve the Department's ability to implement quality improvement and ensure greater accountability for its child protection services. Division responsibilities include:

- auditing clinical files;
- investigating serious events;
- monitoring performance indicators and trends; and
- facilitating improvements in the area of risk management.

It is important that the Department has processes in place to measure whether child protection services are of high quality to ensure the safety and well-being of children and to determine whether services result in improved outcomes for children and families.

We assessed the Department's performance against the following criteria:

A. There are results-oriented goals for the Protective Intervention and In-Care Programs and performance expectations are linked to those goals.

B. The Department identifies and monitors indicators to assess whether performance expectations are being met.

C. The Department monitors and assesses whether the Protective Intervention and In-Care Programs are delivered in accordance with established policies and procedures.

D. Protective Intervention and In-Care Program performance results are reported to the public.

## 5A. Program Goals and Performance Expectations

**Introduction**

An effective system of accountability includes establishing results-oriented goals as well as implementing performance indicators to measure service performance.

**Goals and Performance Expectations Not Established**

Since its creation in 2009, the Department's strategic efforts have focused on transforming the program and service delivery system in order to better protect children and support their well-being and development. We found that results-oriented goals were established in the Department's strategic plans in connection with implementing a new organization structure, improving legislation and improving policies, procedures and systems; however, these goals do not address program and service delivery system performance.

### Finding

49. The Department of Children, Seniors and Social Development had not established results-oriented goals and performance expectations to address program and service delivery system performance.

## 5B. Performance Indicator Monitoring

**Introduction**

Performance measures should be identified and monitored to determine whether performance expectations were achieved and goals were met in key areas such as child safety, permanency and child well-being and development.

**Performance Indicators Not Established**

We found that the Department did not identify and monitor performance indicators to assess the performance of its PIP and In-Care Program. The establishment of indicators is critical to determining how well the Department serves children and families in the areas of child safety, permanency and well-being and development. By not establishing these indicators, the Department diminishes its ability to determine how well it serves children and families.

For example, the Department could monitor the percentage of children in its child protection programs who had parents that received child protection services from the Province as children. A low percentage could indicate how well the Department served children and families. While the Department could not readily determine what percentage of children in its programs had parents that received child protection services as children, we found that:

- In 38% of the 50 PIP files we examined, a child had a parent that received protection services as a child;
- In 44% of the 36 kinship services files we examined, a child had a parent that received protection services as a child; and
- In 48% of the 40 In-Care files we examined, a child had a parent that received protection services as a child.

The Department developed performance indicators in the fall of 2015 which will be used to measure PIP and In-Care program performance in areas of child safety, permanency and well-being. The Department plans to begin using these indicators to monitor program performance when data becomes available through a new Integrated Service Management System in 2017.

**Finding**

50. The Department of Children, Seniors and Social Development did not identify and monitor performance indicators to measure the performance of its Protective Intervention and In-Care Programs.

## 5C. Policy and Procedure Compliance Monitoring

### Introduction

An important component of quality assurance includes monitoring and assessing whether programs and services are being delivered in accordance with established policy and procedures. The Division is responsible for monitoring and assessing whether regional offices comply with the PIP and In-Care policies and procedures.

### No Annual Work Plan or Policies and Procedures

In order to effectively carry out its responsibilities in this area, the Division should have an annual plan and written policies and procedures. We found that the Division did not prepare an annual plan outlining the nature, extent and timing of activities that were required to assess whether regional offices were complying with PIP and In-Care policies and procedures.

The Division carried out the following activities to assess regional office compliance:

- reviewed specific case files at the request of the Department's executive due to a serious incident or issue with the files;
- coordinated special requests from the Department's executive; and
- analyzed data to determine regional office compliance with some components of the Model and In-Care policies and procedures.

However, we found that most of the Division's activities were ad-hoc in nature and did not follow any documented work plan. Furthermore, we found that the Division has not developed comprehensive policies and procedures to support and guide its activities.

**Findings**

51. The Quality Assurance Division has not developed comprehensive policies and procedures to support and guide its activities.

52. The Quality Assurance Division does not prepare annual work plans.

**Data Not Readily Available**

The Department cannot readily access the case file data necessary to effectively monitor and assess whether child protection programs are delivered in accordance with policies and procedures. We found that a significant amount of PIP and In-Care data captured in CRMS is not readily available to the Department as it is in narrative form, or has to be requested from the Office of the Chief Information Officer and then manipulated by the Department to be useful. We also found that significant PIP and In-Care case file information (i.e. FCAPs and IPRs) is not captured electronically and is therefore not readily available to the Division.

A new Integrated Management System is anticipated to be implemented in 2017 which is expected to improve access to the data needed to monitor compliance.

**Finding**

53. The Quality Assurance Division cannot readily access case file data to effectively monitor whether child protection programs are delivered in accordance with policies and procedures.

## 5D. Public Reporting

### Introduction

Public reporting of performance results enhances transparency by providing information on program accomplishments and where program improvements may be required.

### Performance Results Not Reported to the Public

Because the Department has not yet commenced monitoring and reporting to the public on its outcome based performance indicators, the public cannot determine the quality of child protection services provided.

**Finding**

54. The Department of Children, Seniors and Social Development does not report to the public on the performance of its child protection programs.

## Recommendations

1. The decisions of social workers in response to allegations of child maltreatment should be reviewed and approved by supervisors in accordance with the Risk Management Decision Making Model.

2. Social workers should complete and supervisors should review and approve safety assessments, safety plans and protection investigations in accordance with the Risk Management Decision Making Model.

3. Social workers should complete and supervisors should approve Risk Assessment Instruments and Family Centered Action Plans for children in the Protective Intervention Program in accordance with the Risk Management Decision Making Model.

4. Risks to children included on Family Centered Action Plans should be clearly linked to the activities required to reduce those risks.

5. Activities included on Family Centered Action Plans to reduce risks to children should be measureable.

6. Social workers should document on the Family Centered Action Plan whether activities were achieved by the completion dates set and whether risks to children were reduced.

7. Social workers should visit higher risk family homes more frequently than lower risk family homes. The results of these visits should be documented in a timely manner.

8. Social workers should complete and regional managers should approve Kinship Home Assessments prior to placing children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.

9. The Department of Children, Seniors and Social Development should consider reassessing kinship homes that were approved under the previous Child Welfare Allowance Program.

10. The Department of Children, Seniors and Social Development should address the risks to children when they are placed in kinship homes prior to receipt of criminal record and vulnerable sector check documentation from the police.

11. The Kinship Home Assessment Form should be revised to clearly indicate all of the people residing in the kinship homes.

12. Social workers should assess whether parents can financially support their children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.

13. Social workers should prepare and review Kinship Care Agreements in accordance with the Protection and In-Care Policy and Procedure Manual.

14. The Department of Children, Seniors and Social Development should review the level of financial support and social worker monitoring provided to children in kinship homes.

15. Social workers should place children In-Care with placement resources in accordance with the Protection and In-Care Policy and Procedure Manual.

16. Social workers should complete In-Care Progress Reports for children in accordance with the Protection and In-Care Policy and Procedure Manual.

17. The goals and tasks in In-Care Progress Report work plans should be measureable and specific timeframes for completion should be set.

18. Social workers should document on the In-Care Progress Report work plan whether goals and tasks were achieved and the service needs of children were met.

19. The Department of Children, Seniors and Social Development should establish time to permanency expectations for children In-Care.

20. Social workers should visit with children In-Care and placement resources once a month in accordance with the Protection and In-Care Policy and Procedure Manual. The results of these visits should be documented in a timely manner.

21. Social workers should complete annual reviews of regular foster homes in accordance with the Protection and In-Care Policy and Procedure Manual.

22. The Department of Children, Seniors and Social Development should consider implementing annual reviews for relative foster homes.

23. The Department of Children, Seniors and Social Development should establish results-oriented goals and performance expectations to address program and service delivery system performance.

24. The Department of Children, Seniors and Social Development should identify and monitor performance indicators to measure the performance of the Protective Intervention and In-Care Programs.

25. The Quality Assurance Division should develop policies and procedures and annual work plans to support and guide its activities, including the investigation of irregular statistical results in referral screen out rates.

26. The Department of Children, Seniors and Social Development should provide the Quality Assurance Division with the accessible data necessary to monitor whether programs are delivered in accordance with Departmental policies and procedures.

27. The Department of Children, Seniors and Social Development should report program performance results to the public.

# Department Response

***Introduction***

*The Department of Children, Seniors and Social Development (CSSD) acknowledges the findings and accepts the recommendations of the Auditor General's report. CSSD will use this information to assist with efforts to continually improve programs and services for children, youth and families. The report identifies a range of issues that revolve around themes such as documentation and monitoring/review of programs and service delivery. The Department values these findings and will be diligently working to continue improving child protection services.*

*The former Department of Child, Youth and Family Services (CYFS) was created in 2009 and became fully operational in 2012. It was created in response to a series of reports that highlighted deficiencies in areas of workload and workforce stability, case planning, documentation, social worker contact, policy and procedures and risk management. Since the creation of the Department there has been significant progress in creating a structure, policy framework and tools to focus on the provision of high quality child protection services. Some of the major developments of the past several years include:*

- *New Organizational Model – Between 2009 and March 2012, the Department successfully transitioned over 600 staff from the four Regional Health Authorities and implemented a new organizational model consisting of a caseload ratio of 1:20 cases for front line social workers and a revised leadership model to provide necessary clinical supervision to social workers and effective oversight of clinical decisions;*

- *Legislative Reform – implemented legislation,* Children and Youth Care and Protection Act *and the* Adoptions Act 2013*, to ensure policies and programs are aligned with best practices and is responsive to the needs of children and families.*

- *Policy and Procedures – implemented enhanced policies and procedures to inform and support effective service delivery. These policies are continually revised and updated in keeping with emerging research and best practices in child protection;*

- *Staff Training and Development – established a Training Unit to develop and implement a training program focused on assessment, intervention, case planning and documentation. To date this unit has provided training to almost 2000 participants.*

- *Quality Assurance Division – established the division to lead continuous quality improvement initiatives to improve policy/programs and service delivery. It currently reports on 10 monthly, 5 quarterly, 1 semi-annual and 2 annual indicators.*

*Beyond these significant policy and structure changes that have taken place, concurrent with the period of the AG review, the Department has also been taking specific action to focus on improving accountability, policy compliance and quality of services. Some key activities include:*

- *Documentation Review – In January 2015, a targeted review of case documentation of each social worker (with the exception of two zones in Labrador) was completed. As of June 2016, 95 % of outstanding work identified in the review has now been completed.*

- *Supervisory File Reviews – Each month all CYFS supervisors (56 supervisors) complete 1-2 clinical file reviews of the caseload of each social worker on their team. (Approximately 3120 files per year or 260 files per month are reviewed). This process monitors policy compliance including completion of safety assessments, safety plans, protection investigations forms, In-Care Progress Reports, case notes and monthly client visits, where required. In May 2014, the Quality Assurance Division began monitoring and providing feedback to ensure the quality of the supervisor file reviews.*

- *Structured Decision Making Model (SDM) – In 2017, the Department will be implementing a new practice model (SDM) for the Protective Intervention Program. This model will modernize the approach to child protection through the use of more efficient tools to improve the consistency of decision making and strengthen clinical practice.*

- *Integrated Service Management (ISM) project – The ISM project will involve a new computerized case management system for child protection that will replace the current Client Referral Management System (CRMS), which was designed for the health system. With the implementation of ISM, social workers will have tools to better manage their workload and improve documentation and policy compliance. Key features included are due dates for program related forms and overdue notifications. The system will also significantly improve the Department's access to data required to monitor whether programs are delivered in accordance with policies and procedures.*

*Finally, since reviewing the findings of the Auditor General's report the Department has identified a number of initiatives that will be advanced immediately:*

- *Quality Committee - The Department has established a Quality Committee, led by the Assistant Deputy Minister for Corporate Services, whose first task was to oversee the full implementation of the recommendations in this review. Further, an action plan has been developed to improve compliance and monitor work. To advance a culture of organizational learning and continuous improvement, the Department has planned focus groups with social workers and clinical program supervisors. These sessions will present the findings of the action plan and identify solutions to improve adherence to policy and standards to prevent similar issues in the future.*

- *Documentation - In light of the findings that revolve around documentation, the Department has expedited its original implementation plan for a new documentation training module. Working with the MUN School of Social Work, the Department will be taking immediate action to improve its documentation training and will pilot the revised model with clinical program supervisors. This will ensure clinical program supervisors have the tools necessary to support their staff and that improvements in the curriculum can be made prior to delivery to social workers.*

*It is acknowledged across North America that Child Protection work is among the most challenging fields of social work and staff do experience real challenges because of; for example, the demands of the work and recruitment and retention issues. The developments and initiatives just listed, taken together, form a firm foundation from which the Department continues its work to build a transformed child protection system, focused on quality and service excellence. All employees in the Department are steadfastly committed to protecting children and continuing the journey towards being a high performance child protection organization.*

***Response to Recommendations***

***Recommendation 1***

*The decisions of social workers in response to allegations of child maltreatment should be reviewed and approved by supervisors in accordance with the Risk Management Decision Making Model.*

***Departmental Response:***

*The Department agrees with the recommendation and is committed to improving practice in this area.*

*There are several contributing factors that impact supervisory approval of the Child Protection Referral (CPR) form, used to document child maltreatment allegations, not occurring within 24 hours including:*

- *Social workers may complete the referral form in the electronic database (CRMS) after regular working hours, on a Friday evening for example, and the supervisor may not be able to approve the CPR form until Monday morning.*

- *Additional information may be required in order to determine if a protection investigation is required. In these circumstances, the timeframe to obtain and document the required information on a CPR form is extended up to a maximum of 72 hours and therefore the timeframe for supervisory approval of the CPR form is also extended.*

***Recommendation 2***

*Social workers should complete and supervisors should review and approve safety assessments, safety plans and protection investigations in accordance with the Risk Management Decision Making Model.*

***Recommendation 3***

*Social workers should complete and supervisors should approve Risk Assessment Instruments and Family Centered Action Plans for children in the Protective Intervention Program in accordance with the Risk Management Decision Making Model.*

***Departmental Response:***

*The Department agrees with these recommendations and is committed to improving practice in these areas.*

***Recommendation 4***
*Risks to children included on Family Centered Action Plans should be clearly linked to the activities required to reduce those risks.*

***Recommendation 5***
*Activities included on Family Centered Action Plans to reduce risks to children should be measureable.*

***Departmental Response:***
*The Department agrees with these recommendations.*

*The Department agrees that risks identified on the FCAP should be clearly linked to the activities required to reduce those risks and will strive to ensure that activities listed on the FCAP are measurable, where possible. The linking of risk factors with activities and the development of measurable activities on the FCAPs is a clinical decision between the social worker and supervisor and involves collaboration with the client. The process involves a review and assessment of all file information to develop activities to address risks. FCAPs are also reviewed by all parties prior to its signing.*

*The Department acknowledges that some of the FCAPs reviewed did not have measurable activities and is committed to working with front line staff and the Training Unit to improve the practice of developing FCAPs.*

***Recommendation 6***
*Social workers should document on the Family Centered Action Plan whether activities were achieved by the completion dates set and whether risks to children were reduced.*

***Departmental Response:***
*The Department agrees with this recommendation.*

*Current policy requires social workers to document in case notes consultations with clients and supervisors on the progress of Family Centered Action Plans (FCAP). As FCAP activities are completed and risks are reduced, new FCAPs are developed in collaboration with the clients to focus on outstanding activities required to further reduce risk as opposed to documenting what has already been achieved.*

*The Department is also implementing SDM for the Protective Intervention Program and it will include a new* Case Summary *document which will provide easier access to information about a client's progress on the activities outlined in an FCAP.*

*Prior to the implementation of SDM, the Department will review the FCAP and its application and implement the recommended changes where appropriate.*

***Recommendation 7***
*Social workers should visit higher risk family homes more frequently than lower risk family homes. The results of these visits should be documented in a timely manner.*

***Departmental Response:***
*The Department agrees with this recommendation.*

*While interventions, including contact with children and parents, are generally more intensive in higher risk family homes, the frequency of contact with children and families is not solely determined by the assessed risk level. The following factors impact the frequency of visits to a home which may result in a lower risk family being seen more often than a higher risk family at a given time:*

- *The frequency of visits with children and families is informed by a social worker's ongoing assessment of risk which takes into account immediate changes in family circumstances, family strengths, and protective factors which may increase or decrease risk. As risk assessment (RA) forms are completed every 6 or 9 months, the risk rating on the risk assessment may not always reflect current risk level and therefore cannot be the sole determination of how often visits with children and families should occur.*

- *Following the completion of the initial RA and determination of overall risk level, social workers may receive allegations of child maltreatment that require a protection investigation. An investigation would require interviews to be conducted with the parents and children and these visits would increase the frequency of visits with a family that may have initially received a lower risk rating on an RA.*

- *In some high risk rated families, children are temporarily placed outside the home due to safety concerns. As the children are deemed safe in their alternate living arrangement, the frequency of visits to the family home may decrease while the children are out of the home.*

*With respect to documenting visits in a timely manner, the Department is committed to improving documentation practices.*

***Recommendation 8***
*Social workers should complete and regional managers should approve Kinship Home Assessments prior to placing children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Departmental response:***
*The Department agrees with this recommendation.*

*Kinship Home Assessments need to be completed in accordance with policy and is committed to improving practice in this area; however, to ensure their immediate safety during a protection investigation, children may need to live with kin/significant others on an interim basis with parental consent. As the Department is required to ensure children's safety, 24 hours a day, 365 days per year, this immediate living arrangement may occur outside regular business hours. Social workers would complete a number of assessments (i.e. Departmental records check, verbal police checks, interview with kin, observation of home environment) to determine immediate suitability of the kin while a more comprehensive assessment is being completed. To ensure the least intrusive living arrangement for the child, the Department will continue to*

*utilize this approach to ensure the children's safety and to avoid placing children under the Department's care and custody, which is more intrusive for the child.*

***Recommendation 9***
*The Department of Children, Seniors and Social Development should consider reassessing kinship homes that were approved under the previous Child Welfare Allowance Program.*

***Departmental response:***
*The Department agrees with this recommendation and will consider reassessing Kinship Services homes that were approved under the previous CWA program.*

*The policies implemented for the Kinship Services Program were approved for use on a go forward basis only and; therefore CWA homes in place at the time were not reassessed. CWA homes were approved based on key safety assessment criteria that existed at the time to ensure the children's safety and the stability of their living arrangements. However, as part of the regular review of Kinship Services homes, the Department ensures compliance with the current six month review standards.*

***Recommendation 10***
*The Department of Children, Seniors and Social Development should address the risks to children when they are placed in kinship homes prior to receipt of criminal record and vulnerable sector check documentation from the police.*

***Departmental response:***
*The Department agrees with this recommendation.*

*The Department acknowledges the importance of addressing risks to children to ensure their safety and well-being. Current standards to assess the suitability of kinship homes are comprehensive and promote the appropriate gathering of information necessary for social workers to complete a thorough assessment of risks to children and the prospective kinship caregiver's ability to provide a safe and stable home environment for the child.*

*In addition to a discussion with the prospective kinship caregiver, a review of the physical home environment and a Departmental records check, policy requires that copies of criminal records and vulnerable sector checks be obtained within 90 days of the child being placed in a kinship home. This timeframe provides sufficient administrative time for kinship caregivers to apply and obtain these records from policing agencies. To ensure the child's safety in the interim the Department:*

- *completes a verbal records check with the local policing agency on the prospective kinship caregivers and other persons living in the home over the age of twelve. Concerns arising from a verbal records check will be immediately assessed on a case by case basis and inform a decision on the safety and suitability of the living arrangement.*

- *requires prospective kinship caregivers and all persons living in the home over the age of twelve to sign a Self-Declaration and Consent Form advising that he/she does not have a criminal record and providing consent for the Department to verbally obtain a police check.*

*In keeping with the legislative mandate to consider the least intrusive arrangement to ensure the safety of children, the Kinship Service Program is designed to maintain children with family/significant others (e.g. grandparents) and this provides an immediate living arrangement for children who are unable to safely remain at home with their parents, pending further assessment. These interim measures are necessary as without this immediate arrangement children would have to be placed in the Department's care and custody, which is more intrusive for the child.*

***Recommendation 11***

*The Kinship Home Assessment Form should be revised to clearly indicate all of the people residing in the kinship homes.*

***Departmental response:***

*The Department agrees with this recommendation.*

*A new Kinship Home Assessment Form is being implemented to include the names of all children, youth and adults living in the kinship home and their relationship to the proposed kinship caregiver.*

***Recommendation 12***

*Social workers should assess whether parents can financially support their children in kinship homes in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Departmental response:***

*The Department agrees with this recommendation.*

*As per the existing policy, the assessment of the parent's ability to financially support their children does not always occur. CYFS will be reviewing this policy to understand the practice implications of proceeding with implementation.*

***Recommendation 13***

*Social workers should prepare and review Kinship Care Agreements in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Departmental response:***

*The Department agrees with this recommendation and is committed to improving practice in this area.*

***Recommendation 14***

*The Department of Children, Seniors and Social Development should review the level of financial support and social worker monitoring provided to children in kinship homes.*

***Departmental response:***

*The Department agrees with reviewing the level of financial support and social worker monitoring provided to children in kinship homes.*

*The difference in the level of support and monitoring between children residing in kinship homes and children residing in foster homes or other arrangements is largely due to whether the child/youth is in the legal care/custody of the Department.*

*The level of accountability and legal authority is significantly different when the Department uses the most intrusive intervention, which is removal of a child from his or her parents. Removal initiates a court process and the child is then placed in the care/custody of the Department. In comparison, the voluntary nature of the Kinship Services Program involves working collaboratively with parents and kinship caregivers to establish a temporary living arrangement for the child. Kinship homes also require the consent of the parents, who maintain custody of their child and do not have court involvement.*

*Kinship care providers are also entitled to certain financial benefits such as the Child Tax Benefit, and Disability Tax Credit and this is not deducted from the basic rate of financial support provided by the Department. Relative foster homes are not entitled to this financial benefit.*

***Recommendation 15***
*Social workers should place children In-Care with placement resources in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Recommendation 16***
*Social workers should complete In-Care Progress Reports for children in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Departmental response:***
*The Department agrees with these recommendations and is committed to improving practice in these areas.*

***Recommendation 17***
*The goals and tasks in In-Care Progress Report Work Plans should be measureable and specific timeframes for completion should be set.*

***Recommendation 18***
*Social workers should document on the In-Care Progress Report Work Plan whether goals and tasks were achieved and the service needs of children were met.*

***Departmental response:***
*The Department agrees with these recommendations.*

*The Department is committed to working with front line staff and the Training Unit to review the current practice of completing IPR's with a view to clarifying the use of completion dates and developing measurable tasks, where appropriate.*

***Recommendation 19***
*The Department of Children, Seniors and Social Development should establish time to permanency expectations for children In-Care.*

***Departmental response:***
*The Department agrees with this recommendation and is committed to improving practice in this area.*

*The Department recognizes the importance of achieving permanency as quickly as possible for children in care. The Department is committed to reviewing policy and practice and to consulting with other government Departments and community partners and stakeholders to determine how improvements can be made to permanency.*

***Recommendation 20***
*Social workers should visit with children In-Care and placement resources once a month in accordance with the Protection and In-Care Policy and Procedure Manual. The results of these visits should be documented in a timely manner.*

***Departmental response:***
*The Department agrees with this recommendation and is committed to improving practice in this area.*

***Recommendation 21***
*Social workers should complete annual reviews of regular foster homes in accordance with the Protection and In-Care Policy and Procedure Manual.*

***Departmental response:***
*The Department agrees with this recommendation and is committed to improving practice in this area.*

***Recommendation 22***
*The Department of Children, Seniors and Social Development should consider implementing annual reviews for relative foster homes.*

***Departmental response:***
*The Department agrees with this recommendation and will consider implementing annual reviews for relative foster homes.*

***Recommendation 23***
*The Department of Children, Seniors and Social Development should establish results-oriented goals and performance expectations to address program and service delivery system performance.*

***Recommendation 24***
*The Department of Children, Seniors and Social Development should identify and monitor performance indicators to measure the performance of the Protective Intervention and In-Care Programs.*

***Recommendation 25***

*The Quality Assurance Division should develop policies and procedures and annual work plans to support and guide its activities, including the investigation of irregular statistical results in referral screen out rates.*

***Recommendation 26***

*The Department of Children, Seniors and Social Development should provide the Quality Assurance Division with accessible data necessary to monitor whether programs are delivered in accordance with Departmental policies and procedures.*

***Departmental response:***

*The Department agrees with these recommendations and is committed to improving practice in these areas.*

*When the former Department was created in 2009, a phased-in approach to performance monitoring was developed to:*

- *measure whether specific processes were being completed.*
- *measure whether processes were being completed on time in accordance with associated policies and procedures.*
- *measure the impact of Departmental programs and services on children.*

*The implementation of ISM will significantly enhance the Department's ability to monitor whether programs are delivered in accordance with policies and procedures. The Department is committed to improving monitoring of performance indicators and has developed outcome indicators to measure the impact of programs and services on children including safety, well-being and permanency.*

*The Department has completed a recruitment process and will be filling two quality auditor positions in the coming weeks. Adding these new resources to the existing complement of one quality auditor will support the Department in achieving the full breadth of a Quality Assurance Program. These positions will enhance the Department's ability to monitor key performance indicators, investigate irregular statistics in programs, track outcomes for children and youth involved in the Protective Intervention and In Care Programs and promote research to inform evidence-based best practice.*

*Further, the Department will implement a review of its quality management approach as a method to enhance sound clinical decision-making and create a culture of quality.*

***Recommendation 27***

*The Department of Children, Seniors and Social Development should report program performance results to the public.*

***Departmental response:***

*The Department agrees with this recommendation and is committed to improving practice in this area.*

# PART 3.3

# DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

# ACUTE CARE BED MANAGEMENT

# Summary

## Introduction

Regional Health Authorities are responsible for the delivery and administration of health and community services in its region and provincially as designated by the Minister of Health and Community Services. The Department of Health and Community Services strategic direction to Regional Health Authorities is for an accountable, sustainable, quality health and community services system.

For the fiscal year ended March 31, 2015, the Province's health care costs accounted for approximately 40% of the Provincial budget. As of March 31, 2015, 18% of the population in the Province was aged 65 and older and it is predicted that adults aged 65 and older will make up 31% of the population by 2034. An ageing population will result in a higher demand for acute care services in the future.

Bed management is the allocation and provision of acute care beds. The proper management of acute care patient services, including the timely, safe and appropriate admission, placement, treatment and discharge from hospital, are vital to the well-being of patients and the efficient and effective functioning of the organization. As such, acute care bed management should optimize bed utilization and ensure patients are admitted to the most appropriate program area in a timely manner to receive safe and quality care.

Functional acute care beds are defined as appropriately staffed and operational hospital beds for medical, surgical, obstetrical, pediatric, psychiatric and critical care patients. Acute care beds exclude hospital beds that are allocated for rehabilitation, long-term and palliative care, and beds that are intended for temporary occupancy.

## Objective

The objective of our audit was to determine whether Regional Health Authorities effectively manage patient flow with respect to acute care bed management.

## Scope

Our audit covered the period January 1, 2015 to September 30, 2015. In addition, historical trends were analyzed for the three-year period ending March 31, 2015. Our audit included an examination of four hospitals - one hospital at each of the four Regional Health Authorities as follows:

1. Eastern Regional Health Authority – Health Science Centre;

2. Western Regional Health Authority – Western Memorial Regional Hospital;

3. Central Regional Health Authority– Central Newfoundland Regional Health Centre; and

4. Labrador-Grenfell Regional Health Authority – Labrador Health Centre

Our audit included interviews with Regional Health Authority officials and an examination of documentation including policies and procedures, strategic plans, annual reports and other internal reports. We analyzed statistical data for each hospital to identify trends and progress made towards established performance benchmarks. We also visited each of the four hospitals to determine how each manages patient flow with respect to acute care bed management. For the four hospitals, we sampled a total of 155 patient health records to perform audit procedures on the admission and discharge information contained in these health records. Sample selection was non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

## Importance to Newfoundlanders and Labradorians

Regional Health Authorities provide services to patients across the continuum of care. A significant portion of health care expenditure is allocated to hospitals to provide acute care services to patients. According to the Canadian Institute for Health Information, it was estimated that the cost of a standard hospital stay in the Provincial health care system for the year ended March 31, 2015 was $6,252. Therefore, it is essential that hospitals have an effective process to ensure that patients are admitted to and discharged from hospitals in an efficient manner and that improved access to beds for awaiting patients is provided. An interdisciplinary approach to discharge planning helps patients and families prepare for a safe and timely transition from hospital.

## Conclusion

**Objective**

The four Regional Health Authorities are managing patient flow with respect to acute care bed management, however:

- National performance indicators and benchmarks are not always used by the Regional Health Authorities to effectively manage and monitor acute care beds;

- Policies, procedures, processes and systems for managing and monitoring acute care bed management are not always complete and comprehensive; and

- Actual results for the four hospitals that we examined at the Regional Health Authorities are not always within National benchmarks established for key performance indicators and best practice in the health care sector.

# Findings

## Acute Care Bed Management

***Performance Goals and Objectives***

1. Although not specifically identified, the Regional Health Authorities' goals and objectives for acute care bed management were embedded in their strategic and operational goals and objectives.

***Performance Indicators and Benchmarks***

2. Three of the four hospitals that we examined monitored their acute care beds and patient flow using a number of performance indicators that are considered best practice. Although the information is available to the hospital, Labrador Health Centre did not use and monitor key performance indicators to manage their acute care beds and patient flow.

***Bed Management Processes***

3. Three of the four Regional Health Authorities' (Western, Central and Labrador-Grenfell) policies and procedures were not always complete, comprehensive or documented in guiding staff in managing acute care beds or effectively admitting and discharging patients.

4. None of the four hospitals that we examined required a patient's expected discharge date to be documented by a physician and inputted in the hospitals' health care information system. Without documenting the expected discharge date, hospitals cannot effectively monitor actual discharge dates and whether delays in discharges are captured and followed up.

5. The discharge planning section of the patient history form was not always completed for the patient records that we examined for Health Science Centre.

6. The admission assessment form was not always completed for the patient records that we examined for Labrador Health Centre.

7. The high risk indicator assessments were not always completed for the patient records that we examined for Health Science Centre and Labrador Health Centre.

8. For three of the four hospitals that we examined, the Regional Health Authorities did not require medication reconciliations to be performed at discharge.

9. Only 3 of the 33 applicable patient records that we examined at the Western Memorial Regional Hospital had medication reconciliations at discharge performed as required by the Western Regional Health Authority.

10. Patient discharge instructions forms were not always completed for the patient records that we examined at Central Newfoundland Regional Health Centre and the Health Science Centre.

11. Western, Central and Labrador-Grenfell Regional Health Authorities did not provide standardized discharge summaries to be prepared by physicians.

12. Discharge summaries were not always completed for the patient records that we examined at Western Memorial Regional Hospital and Labrador Health Centre.

13. Discharge summaries were not always completed by the required deadlines for Western Memorial Regional Hospital and Central Newfoundland Regional Health Centre.

14. All four hospitals that we examined either had a dedicated admission/discharge manager that was solely responsible for acute care bed management or designated positions whose duties included bed management.

15. Labrador-Grenfell Regional Health Authority did not have a data analyst/decision support position to compile statistics for performance indicators related to bed management.

16. All four hospitals held regular staff meetings to discuss the availability of acute care beds and the status of specific patient admissions and discharges. However, bed huddles and multidisciplinary meetings were not held during the weekend and recommended staff did not always attend these meetings.

17. All four hospitals that we examined used unit whiteboards as a communication tool to assist staff in meeting discharge goals but did not always record an expected discharge date.

18. All four hospitals that we examined had white boards located in a patient's room, however, information recorded on the whiteboards varied in detail, and only the Labrador Health Centre recorded the patient's expected discharge date.

19. None of the four hospitals that we examined had performance indicators and systems in place to monitor the timing of referrals for community and other health services in order to identify delays against benchmarks.

20. None of the four hospitals that we examined had a formal process for reviewing acute care patient admissions to ensure the admission was necessary and for assessing patients with extended lengths of stay.

21. Only one of the four hospitals that we examined, the Health Sciences Centre, had a structured reporting tool, a "scorecard", that was provided to senior management on a regular basis with statistical and performance information to effectively monitor actual results against benchmarks for key performance indicators. Western Memorial Regional Hospital, Central Newfoundland Regional Health Centre and Labrador Health Centre prepared scorecards but they provided limited statistical and performance information related to acute care patient flow.

22. Although all four hospitals that we examined used information systems and tools to manage acute care beds and track and monitor results, certain hospitals did not fully utilize these systems. We found that:

    - Central Newfoundland Regional Health Centre's newly implemented bed manager system could not provide historical trend reports;
    - Labrador Health Centre did not use electronic bed boards, which are used to report the status of beds to responsible staff; and
    - Western Memorial Regional Hospital and Labrador Health Centre did not have an information system to track and monitor the cleaning of beds and Central Newfoundland Regional Health Centre did not compile the information for statistical monitoring.

23. Regional Health Authorities did not enter into repatriation agreements with one another to ensure that transferred patients are transferred back to the originating hospital once the patient's acute care treatment is finished at the second hospital and the patient still requires further acute care services. This may cause delays in patient transfers and create bottlenecks in the acute care system.

24. All four hospitals that we examined had a complaints process in place.

25. All four hospitals that we examined had an occurrence reporting process in place.

26. Three of the four hospitals that we examined completed patient satisfaction surveys. Labrador Health Centre did not have a patient satisfaction survey completed.

***Actual Results versus Performance Benchmarks***

27. All four hospitals that we examined had bed occupancy rates higher than the National benchmark of 85%. For 2015, the overall bed occupancy rates at the four hospitals that we examined ranged from 91% to 96%.

28. Patients admitted through the Emergency Department at the Health Science Centre were not placed in an acute care bed within the National benchmark of eight hours. The Labrador Health Centre did not capture actual results for this performance indicator.

29. All four hospitals that we examined had acute care beds being occupied by Alternate Level of Care patients that did not require acute care services. For three of the four hospitals that we examined (Health Science Centre, Western Memorial Regional Hospital and Central Newfoundland Regional Health Centre) the majority of Alternate Level of Care patients were waiting for continuing care placements in long-term care facilities or personal care homes. For the year ended March 31, 2015, the percentage of Alternate Level of Care patient days to total patient days ranged from a low of 12% for Health Science Centre to in excess of 30% at Central Newfoundland Regional Health Centre, Western Memorial Regional Hospital and Labrador Health Centre.

30. The average length of stay of Alternate Level of Care patients at three of the four hospitals that we examined was high. For the year ended March 31, 2015, the Alternate Level of Care average length of stay for Central Newfoundland Regional Health Centre, Western Memorial Regional Hospital and Labrador Health Centre was in excess of 77 days.

31. For the four hospitals that we examined, two hospitals reported average lengths of stay that exceeded the National expected lengths of stay for identified acute care treatments for medicine and surgery for the period January 2015 to September 2015. For medicine, the average lengths of stay exceeded the expected lengths of stay by 3.75 days for Western Memorial Regional Hospital and 3.98 days for Central Newfoundland Regional Health Centre. For surgery, the average lengths of stay exceeded the expected lengths of stay by 0.45 days for Western Memorial Regional Hospital and 0.65 days for Health Science Centre.

32. All four Regional Health Authorities admitted patients with Ambulatory Care Sensitive Conditions above the National benchmark for these types of patients.

33. All four hospitals that we examined were not discharging patients during the morning, consistent with best practice. 61% to 69% of patients were being discharged from noon to 6:00 p.m.

34. Best practice recommends that discharges should be distributed evenly throughout the week. All four hospitals that we examined were not discharging patients on weekends at the same rate as weekday discharges.

35. One of the four hospitals (Labrador Health Centre) that we examined had a readmission rate for surgical and medical patients that were above the National benchmark for such readmissions.

***Implementation of Action Plans and Strategies***

36. All four hospitals that we examined have implemented a number of strategies and action plans to improve patient flow as it relates to acute care bed management. Issues with bed availability, occupancy rates, non-acute care admissions and hospital stays, extended lengths of stay, discharges and readmissions have been identified within each Regional Health Authority, requiring their continued efforts.

## Recommendations

1. Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.

2. Regional health authorities should develop acute care bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.

3. Regional health authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patient rooms, early discharge times, patient transfer/repatriation protocols, and information systems that promote good planning and monitoring of acute care bed usage/availability.

4. Regional health authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.

## Importance of implementing these recommendations

If our recommendations are not implemented, there is a risk that Regional Health Authorities may not maintain effective and efficient processes in admitting and discharging acute care patients from hospitals. This could result in non-acute care patients being admitted and cared for in acute care beds, increased or unnecessary lengths of stay, unnecessary wait times for patients awaiting acute care services, patient safety concerns, and increased costs.

# Objective and Scope

## Objective

The objective of our audit was to determine whether Regional Health Authorities (RHAs) effectively manage patient flow with respect to acute care bed management.

Criteria were developed specifically for this audit based upon relevant legislation, RHA policies and procedures, our related work, reviews of literature including reports of other legislative auditors, and consultations with management. The criteria were accepted as suitable by the senior management of each of the four RHAs.

## Scope

Our audit covered the period January 1, 2015 to September 30, 2015. In addition, historical trends were analyzed for the three-year period ended March 31, 2015. Our audit included an examination of four hospitals - one at each of the four RHAs.

Our audit included interviews with RHA officials and an examination of documentation including policies and procedures, strategic plans, annual reports and other internal reports. We analyzed statistical data for each hospital to identify trends and progress made towards established performance benchmarks. We also visited each of the four hospitals to determine how each manages patient flow with respect to acute care bed management. For the four hospitals, we examined a sample of 155 patient health records to perform audit procedures on the admission and discharge information contained in these health records. Sample selection was non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

# Background

Regional Health Authorities (RHAs) are responsible for the delivery and administration of health and community services in its region and provincially as designated by the Minister of Health and Community Services. The Department of Health and Community Services strategic direction to RHAs is for an accountable, sustainable, quality health and community services system.

For the fiscal year ended March 31, 2015, the Province's health care costs accounted for approximately 40% of the Provincial budget. As of March 31, 2015, 18% of the population in the Province was aged 65 and older and it is predicted that adults aged 65 and older will make up 31% of the population by 2034. An ageing population will result in a higher demand for acute care services in the future.

Table 1 provides an overview of the acute care beds, admissions and patient days at each of the four hospitals that we included in our audit scope.

**Table 1**

**Regional Health Authorities**
**Acute Care Bed Management**
**Sample Hospitals**
**Acute Care Beds, Admissions and Patient Days**
**For the Year Ended March 31, 2015**

| Regional Health Authority (RHA) and Hospital | Number of Acute Care Beds | Number of Admissions | Number of Patient Days |
|---|---|---|---|
| Eastern RHA – Health Science Centre (HSC) | 346 | 14,728 | 118,136 |
| Western RHA – Western Memorial Regional Hospital (WMRH) Note 1 | 217 | 6,601 | 72,563 |
| Central RHA – Central Newfoundland Regional Health Centre (CNRHC) | 117 | 3,688 | 42,579 |
| Labrador-Grenfell RHA – Labrador Health Centre (LHC) | 25 | 1,438 | 9,061 |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

Note 1: WMRH has included information related to 16 beds in total in its palliative care unit and rehabilitation unit.

The four hospitals that we selected for examination vary in size, available resources, operational environments and service levels, and as such, are not comparable organizations within the Province's health care system.

# Detailed Observations

## Acute Care Bed Management

**Objective**

The objective of our audit was to determine whether RHAs effectively manage patient flow with respect to acute care bed management.

### Conclusion

The four Regional Health Authorities are managing patient flow with respect to acute care bed management, however:

- National performance indicators and benchmarks are not always used by the Regional Health Authorities to effectively manage and monitor acute care beds;
- Policies, procedures, processes and systems for managing and monitoring acute care bed management are not always complete and comprehensive; and
- Actual results for the four hospitals that we examined at the Regional Health Authorities are not always within National benchmarks established for key performance indicators and best practice in the health care sector.

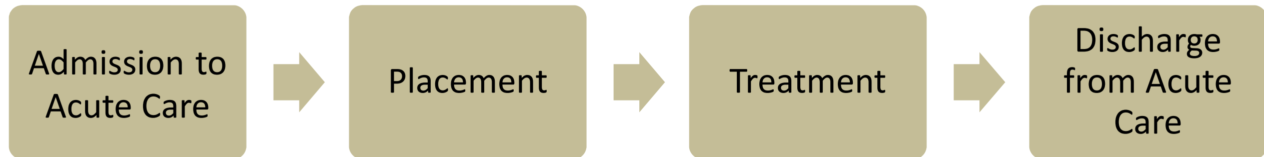
**Overview**

Bed management is the allocation and provision of acute care beds. The proper management of acute care patient services, including the timely, safe and appropriate admission, placement, treatment and discharge from hospital, are vital to the well-being of patients and the efficient and effective functioning of the organization. As such, acute care bed management should optimize bed utilization and ensure patients are admitted to the most appropriate program area in a timely manner to receive safe and quality care.

Functional acute care beds are defined as appropriately staffed and operational hospital beds for medical, surgical, obstetrical, pediatric, psychiatric and critical care patients. Acute care beds exclude hospital beds that are allocated for rehabilitation, long-term and palliative care, and beds that are intended for temporary occupancy.

**Figure 1**

**Regional Health Authorities**
**Acute Care Bed Management**
**Acute Care Bed Management Process**




RHAs should have an effective acute care bed management process to optimize bed utilization while ensuring patients are provided with quality health care in a safe and timely manner.

We assessed the RHAs performance against the following criteria:

A. Performance goals and objectives have been established.

B. Benchmarks have been established for performance objectives which reflect best practices and national standards.

C. Policies, procedures and systems are established and implemented to guide how performance goals and objectives are met.

D. Actual results are measured against performance benchmarks.

E. Action plans and strategies are implemented to address deficiencies identified when performance benchmarks are not met.

In assessing the RHAs performance against these criteria, we considered a number of best practices in the health care industry as it related to acute care bed management. Best practices were taken from a number of sources including the Canadian Institute for Health Information, Accreditation Canada, Wait Time Alliance, various health care management institutions, various health care research papers, other jurisdictional auditor general reports, and provincial RHA policies, procedures, practices and standards of care.

## A. Performance Goals and Objectives

### Introduction

In accordance with the *Regional Health Authorities Act*, RHAs are required to develop objectives and priorities for the provision of health and community services which meet the needs of its region and which are consistent with provincial objectives and priorities.

### Performance Goals and Objectives

Our audit included interviews with RHA officials and an examination of RHA strategic plans, annual plans and other operational plans to determine whether performance goals were established at the RHAs relating to acute care bed management.

The RHAs had documented strategic goals that related to population health, patient access and the quality of care and efficiency/sustainability. Although the RHAs did not have performance goals specific to acute care bed management, some of the strategic goals as reported by each RHA did encompass goals related to acute care bed management. For example:

- Eastern RHA's goal for access is *"Eastern Health will have improved access by providing the right intervention at the right time and the right place."*

- Western RHA's goal for access to emergency room services is "*Western Health will have improved access to emergency room services in keeping with the provincial strategy."*

- Central RHA's goal for client flow is *"Central Health will have reduced and mitigated overcrowding in the emergency department by improving client flow."*

- Labrador-Grenfell RHA's goal for improved performance is *"Labrador Grenfell Health will have implemented initiatives to achieve greater operational efficiency in the delivery of health care in the region."*

Western RHA also prepared branch plans for specific functional areas (i.e. patient services) which provided further operational goals, which also encompassed acute care bed management. For example, operational goals included: "*To promote continued excellence in patient care*" and "*To promote continued excellence in resource management*". Eastern RHA prepared operational plans for specific units, and the goals identified in the operational plans were in line with the strategic goals. Central RHA prepared a client flow work plan which supported its strategic goal in this area and focused on improving client flow to reduce overcrowding in the Emergency Department. Labrador-Grenfell RHA did not prepare operational, branch or work plans.

Objectives are required to be specific, time sensitive and measurable in order to be effective in ensuring goals are achieved. For each RHA, we identified that objectives were established for each performance goal, however, they were not always specific to acute care bed management.

## Finding

1. Although not specifically identified, the Regional Health Authorities' goals and objectives for acute care bed management were embedded in their strategic and operational goals and objectives.

## B. Performance Indicators and Benchmarks

### Introduction

In order to determine whether goals and objectives are being met, it is important that performance indicators are identified and that benchmarks and targets for each performance indicator are established. Actual results can then be compared to these benchmarks and targets to determine whether hospitals are performing above or below their expectations.

For the health care system, performance indicators and benchmarks have been established on a national basis through the Canadian Institute for Health Information (CIHI) or provincially by each RHA. Hospitals submit financial and statistical data to CIHI in accordance with national Management Information Systems (MIS) Standards, who in turn compile the data nationally, develop benchmarks and report the data and indicators to health providers for resource and management decisions. RHAs may also develop specific performance indicators and benchmarks/targets for their operational needs.

### Performance Indicators and Benchmarks

RHAs captured a number of key statistics to assess the supply and demand for beds, to highlight potential capacity issues and to establish trends over time and comparisons amongst other similar size hospitals. Key statistics included the number of patients waiting for a bed, number of cancelled surgeries, discharge destinations of patients, and percentage of patients admitted through the Emergency Department, direct, day surgery, or clinic.

In addition to compiling and examining statistics, a number of performance indicators were available to an RHA to assess the utilization of acute care beds and patient flow.

Table 2 provides a number of key performance indicators that are based on best practice.

**Table 2**

**Regional Health Authorities**
**Acute Care Bed Management**
**Performance Indicators and Benchmarks**

| Performance Indicator | Benchmark | Performance Indicator Monitored | | | |
|---|---|---|---|---|---|
| | | HSC | WMRH | CNRHC | LHC |
| Bed occupancy | Below 85% | YES | YES | YES | YES |
| Alternate Level of Care patient days | Zero | YES | YES | YES | NO |
| Average number of patients admitted and discharged hourly and daily. | - Majority of discharges before 11a.m.<br>- Discharges should be evenly distributed throughout the week | YES | YES | YES | NO |
| Percent of patients that exceed their expected length of stay (ELOS) by case mix grouping. | Not to exceed ELOS | YES | YES | YES | NO |
| Percent of patients that exceed their ELOS by physician. | Not to exceed ELOS | YES | YES | NO | NO |
| Ambulatory Care Sensitive Conditions (ACSC) rate by RHA | Not to exceed 331 cases per 100,000 population | YES | YES | YES | NO |
| Emergency Department wait time for a bed | 8 hours | YES | YES | YES | NO |
| Unscheduled readmission rate | Specific to patient service and size of hospital | YES | YES | YES | NO |
| Time to clean beds | - ½ hour for standard bed<br>- 1 ½ hours for isolation bed | YES | NO | NO | NO |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon information obtained from RHAs.

## Finding

2. Three of the four hospitals that we examined monitored their acute care beds and patient flow using a number of performance indicators that are considered best practice. Although the information is available to the hospital, Labrador Health Centre did not use and monitor key performance indicators to manage their acute care beds and patient flow.

## C. Bed Management Processes

### Introduction

The timely, safe and appropriate admission and discharge of patients from hospitals is vital to the well-being of patients and the efficient and effective functioning of a hospital. Effective bed management helps to ensure:

- beds are available for emergency admissions;
- beds are available for elective patients;
- the quality and appropriateness of care is high;
- there is a plan for patients to get the care they require after discharge from hospital; and
- financial resources are used appropriately.

Documented policies and procedures and effective admission and discharge systems and processes assist clinical staff and physicians with the management of acute care beds and patient flow.

**Policies and Procedures**

Documented bed management policies and procedures support and guide staff. They inform decision-making, promote consistent work practices and communicate expectations regarding bed management. Policies, procedures and guidelines should be documented for bed management decisions, admission and assessments, completion of health records, alternate level of care (ALC) patients, medication reconciliation and patient discharges.

Eastern RHA had documented bed management policies and procedures. The remaining three RHAs (Western, Central and Labrador-Grenfell) had documented bed management policies and procedures, however, there were variations to the extent to which they provided guidance to staff.

**Finding**

3. Three of the four Regional Health Authorities' (Western, Central and Labrador-Grenfell) policies and procedures were not always complete, comprehensive or documented in guiding staff in managing acute care beds or effectively admitting and discharging patients.

**Expected Discharge Date**

Early planning provides hospital staff with the best opportunity to address any risks to timely discharge, helps to inform the patient and their family of when they are likely to be discharged and assists the hospital to better predict its admissions and discharges. For elective surgery patients, discharge planning should start when they undergo their pre-admission assessment. For unplanned admissions from the emergency department, discharge planning should start on the first day of the patient stay.

None of the four hospitals that we examined required physicians to record the expected discharge date for patients at time of admission in Meditech, the electronic health care information system used by all four RHAs. Physicians and/or nursing staff discuss the expected discharge date with elective surgery patients during pre-admission or upon admission. Without documenting the expected discharge date, hospitals cannot effectively assess actual discharge dates and whether discharge delays exist.

## Finding

4. None of the four hospitals that we examined required a patient's expected discharge date to be documented by a physician and inputted in the hospitals' health care information system. Without documenting the expected discharge date, hospitals cannot effectively monitor actual discharge dates and whether delays in discharges are captured and followed up.

**Patient Admission and Discharge Documentation**

We examined a sample of 155 patient records to determine whether certain procedures and forms were completed to ensure the proper admission and discharge of the patient. We examined:

- admission assessments (high risk indicators and discharge planning);
- medication reconciliations;
- discharge instructions; and
- discharge summaries.

***Admission Assessments (High Risk Indicators and Discharge Planning)***

Patients should be screened for risk factors within 24 hours of admission using standardized criteria to identify potential barriers that may delay discharge (e.g. risk of falls and pressure ulcers, cognitive ability, personal hygiene, mobility, psychosocial issues and social supports).

Each RHA completed different nursing admission forms or used different Meditech versions to assess patients. For example, LHC did not utilize Meditech's nursing module which would have provided easier access to a patient's record and allow for better monitoring.

A patient discharge plan ensures that patients are discharged at an appropriate time and with provision of adequate post-discharge services. Proper discharge planning also determines the appropriate level of services required by a patient and then matches the patient to an appropriate care. This process should begin at the start of the hospitalization.

For our sample of 155 patient records, we found the following issues:

**HSC**

- 15 of 50 patient records did not have the discharge planning section of the patient history form completed.

- 9 of 50 patient records did not have the pressure ulcers and falls assessments completed.

**LHC**

- 12 of 35 patient records did not have the admission assessment form completed. Of the 23 forms completed, 14 forms were only partially completed.

- 20 of 35 patient records did not have the pressure ulcers and falls assessments completed.

## Findings

5. The discharge planning section of the patient history form was not always completed for the patient records that we examined for Health Science Centre.

6. The admission assessment form was not always completed for the patient records that we examined for Labrador Health Centre.

7. The high risk indicator assessments were not always completed for the patient records that we examined for Health Science Centre and Labrador Health Centre.

***Medication Reconciliation at Discharge***

Best practice requires the completion of medication reconciliations which are used to create the most accurate list possible of all medications a patient is taking. Our examination of medication reconciliations at the four hospitals identified the following:

- For three of the four hospitals that we examined (HSC, CNRHC, LHC), the RHAs did not require physicians to perform medication reconciliations upon a patient's discharge; and

- WMRH required medication reconciliations upon a patient's discharge, however, only 3 of the 33 applicable patient records that we examined had medication reconciliations completed.

**Findings**

8. For three of the four hospitals that we examined, the Regional Health Authorities did not require medication reconciliations to be performed at discharge.

9. Only 3 of the 33 applicable patient records that we examined at the Western Memorial Regional Hospital had medication reconciliations at discharge performed as required by the Western Regional Health Authority.

***Patient Discharge Instructions Form***

Patient discharge instructions are to be provided to patients/families at the time of discharge and should include information such as follow-up appointments with healthcare providers, referrals, teaching materials, medication list and plan of care instructions. Not providing a patient with adequate instructions increases the risk that patients will be readmitted. We found that the four hospitals that we examined had patient discharge instructions prepared with the exception of the following:

- 6 of 50 patient records examined at the HSC did not have a patient discharge instructions form completed; and

- 4 of 35 patient records examined at the CNRHC did not have a patient discharge instructions form completed.

**Finding**

10. Patient discharge instructions forms were not always completed for the patient records that we examined at Central Newfoundland Regional Health Centre and the Health Science Centre.

***Discharge Summary***

The discharge summary is a record prepared by the physician responsible for the patient and is used to transfer information about the patient to post-discharge healthcare providers. The discharge summary provides a synopsis of a patient's admission to hospital and the clinical care provided, as well as information pertinent for the continuation of health care following discharge.

Discharge summaries could be dictated by a physician and then transcribed into Meditech or prepared using a paper form and scanned into Meditech. Three of the four RHAs (Western, Central and Labrador-Grenfell) did not provide standardized discharge summaries to be prepared by physicians.

Each hospital required discharge summaries to be completed within a certain time period of a patient's discharge. WMRH, CNRHC, and LHC required discharge summaries to be dictated and transcribed within 28 days of patient discharge. The HSC required hard-copy discharge summaries to be scanned and filed in Meditech within 24 hours of discharge. We found that the four hospitals that we examined filed discharge summaries as required except for the following:

- Two of the four hospitals that we examined did not always complete discharge summaries. 5 of 35 discharges at WMRH and LHC each did not have an electronic discharge summary or a paper discharge summary completed.

- Two of the four hospitals that we examined did not always complete their discharge summaries within the required deadlines. 5 of 30 discharge summaries examined at WMRH were not completed within 28 days of discharge, ranging from 6 to 42 days past due. 6 of 35 discharge summaries examined at CNRHC were not completed within 28 days of discharge, ranging from 5 to 198 days past due.

## Findings

11. Western, Central and Labrador-Grenfell Regional Health Authorities did not provide standardized discharge summaries to be prepared by physicians.

12. Discharge summaries were not always completed for the patient records that we examined at Western Memorial Regional Hospital and Labrador Health Centre.

13. Discharge summaries were not always completed by the required deadlines for Western Memorial Regional Hospital and Central Newfoundland Regional Health Centre.

**Bed Management Processes and Information Systems**

The availability of appropriate patient beds is impacted by a hospital's bed management practices. The need to balance competing demands for acute patient care with emergency and elective surgery patients makes bed management a complex task. We examined the following areas to assess how well the four hospitals managed their patient beds:

- bed management processes; and

- bed management information systems.

***Bed Management Processes***

Bed Managers

Best practice for effective bed management is to have dedicated bed managers (admission/discharge managers) that have the appropriate authority and accountability to facilitate all aspects of patient flow as it relates to bed management. The responsibilities of bed managers would commonly include coordinating admissions, optimizing bed resources, allocating beds on the basis of clinical need, liaising and communicating with other relevant individuals and participating in relevant meetings and improvement projects.

All four hospitals that we examined had designated positions responsible for bed management, however, the duties of the positions varied depending upon the hospital and the day/time of the week. For example:

- Both HSC and WMRH had admission/discharge managers dedicated specifically for bed management from Monday to Friday – 8:00 am to 4:00 pm.

- CNRHC and LHC did not have designated admission/discharge managers, however, both hospitals had staff that had shared responsibilities which included managing acute care beds and patient flow.

- None of the four hospitals that we examined had a dedicated bed manager on staff during evening shifts and weekends. However, site managers, whose duties included acute care bed management, were either on site or on call during evening shifts and weekends.

A data analyst/decision support employee provides support to bed managers and other management by interpreting performance indicators, designing and implementing systems to establish benchmarks, compiling statistics, comparing results and identifying regional, provincial and national trends and variances. Three of the four RHAs had a dedicated data analyst/decision support employee, however, Labrador-Grenfell RHA did not have an employee that performed these duties.

## Findings

14. All four hospitals that we examined either had a dedicated admission/discharge manager that was solely responsible for acute care bed management or designated positions whose duties included bed management.

15. Labrador-Grenfell Regional Health Authority did not have a data analyst/decision support position to compile statistics for performance indicators related to bed management.

## Bed Management Meetings

Bed management meetings are integral to the bed management process. Best practice is to conduct daily bed huddles and daily multidisciplinary meetings (bullet rounds).

### *Bed Huddles*

Bed huddles are meetings held early in the morning to discuss and report on a hospital's current bed status, anticipated admissions, anticipated transfers and anticipated discharges. In order to provide a coordinated approach to managing acute care beds, bed huddles would be attended by unit managers or representatives and admission/discharge managers.

All four hospitals that we examined conducted bed huddles each weekday, however:

- Meetings were not held on weekends.

- Since October 2015, CNRHC stopped having official bed huddles, and meetings were held individually with care facilitators and unit managers. Meeting individually with staff may result in meetings being time-consuming and could result in a less coordinated effort in managing beds.

### *Multidisciplinary Meetings (Bullet Rounds)*

Multidisciplinary meetings (bullet rounds) are meetings which are held daily to monitor a patient's readiness to discharge/transfer from a hospital in order for all departments to coordinate anticipated discharge dates. The meetings are usually attended by representatives from the various departments involved in a patient's care such as the physician, nurse manager, staff nurses, pharmacists, social workers, nutritionists, therapists, case manager, and discharge planners. Discharge plans and identified issues for each patient are discussed and action plans are updated.

All four hospitals that we examined held regular multidisciplinary meetings, however, only HSC held them each weekday (Monday to Friday) for each unit and WMRH's orthopedic unit held meetings each weekday. We found the attendance at multidisciplinary meetings varied depending on the hospital that we visited. Physicians attended multidisciplinary meetings at LHC. At the other three hospitals, physicians only attended meetings in the ICU and mental health units, or when their schedules allowed them to attend.

### Finding

16. All four hospitals held regular staff meetings to discuss the availability of acute care beds and the status of specific patient admissions and discharges. However, bed huddles and multidisciplinary meetings were not held during the weekend and recommended staff did not always attend these meetings.

Whiteboards

Whiteboards are an important visual communication tool for supplying critical information to staff and patients and to assist in meeting a patient's discharge date and goals. To be effective, whiteboards should be placed at each unit and in each patient room.

All four hospitals that we examined had white boards located in each unit which were used to record the room number, patients' name, nurse assigned, responsible physician, status of referrals, expected discharge date and comments. During our site visits to the four hospitals that we examined, the expected discharge date was not always recorded on the unit white boards. In addition, different units had less information recorded, for example, CNRHC medicine units did not record the status of referrals.

All four hospitals that we examined had whiteboards located in a patient's room to assist multi-disciplinary members in their meetings with patients and to act as a communication tool to inform patients of their expected discharge date and discharge goals. Depending upon the hospital and unit, the whiteboards recorded varying information. For example:

- HSC and WMRH whiteboards in patient rooms usually recorded the current date, room number, patient's name, the responsible nurse, the physician name, appointments within the hospital and any family notes. The whiteboards did not include the patient's expected discharge date.

- CNRHC whiteboards in patient rooms varied in information provided, but usually only recorded the responsible nurse. The whiteboards did not include the patient's expected discharge date.

- LHC whiteboards in patient rooms provided the current date, room number, patient's name, phone number, responsible nurse, clinical nurse manager, referral services, physician, expected date of discharge, daily plan of care, pain scale, and any patient or family notes.

Since March 2015, monthly formal audits were conducted by the nurse manager at LHC of whiteboards in patient rooms to ensure they were completed as required. HSC, WMRH and CNRHC did not have a process in place to ensure that whiteboards included necessary information to assist with a patient's discharge goals.

## Findings

17. All four hospitals that we examined used unit whiteboards as a communication tool to assist staff in meeting discharge goals but did not always record an expected discharge date.

18. All four hospitals that we examined had white boards located in a patient's room, however, information recorded on the whiteboards varied in detail, and only the Labrador Health Centre recorded the patient's expected discharge date.

Referral Services

The provision of timely referral services is an essential part of managing patient flow and ensuring patients are discharged in a timely manner.

Referrals are sometimes made for patients requiring allied health services such as occupational therapy, physiotherapy, speech language pathology, social work, and dietetics. Until these services are provided, the patient's discharge may be affected.

Also, patients sometime require community health and other referral services to be provided once they have been discharged such as wound care, homecare, oxygen services, etc. Until the referral or service is confirmed the patient's discharge may be affected.

It is important that hospitals capture and monitor the timeliness of the provision of these services in order to determine if and where delays are occurring. None of the hospitals that we examined had performance indicators and systems in place to track the timing of referrals which would identify delays with such services against benchmarks.

**Finding**

19. None of the four hospitals that we examined had performance indicators and systems in place to monitor the timing of referrals for community and other health services in order to identify delays against benchmarks.

Patient Chart Reviews

Hospitals should perform regular chart reviews to ensure patient placement in acute care is reflective of the patient's care requirements or that patients with extended lengths of stay are investigated. However, from discussions with hospital officials, these reviews, if conducted, were informal and not documented.

**Finding**

20. None of the four hospitals that we examined had a formal process for reviewing acute care patient admissions to ensure the admission was necessary and for assessing patients with extended lengths of stay.

Scorecards

"Scorecards" are periodic reports provided to senior management and the Board of Directors on statistics and performance indicators. The use of "scorecards" can be an effective management tool for reporting and monitoring the status of acute care beds and patient flow.

The HSC's "scorecard", which was updated every three months, was informative and was presented well. The "scorecard" provided various performance indicators which were linked to the strategic plan and for each performance indicator provided information on national benchmarks, RHA targets, actual results, status, trends, analysis and action plans for areas where benchmarks and targets were not met.

WMRH, CNRHC and LHC prepared quarterly scorecards but they provided limited statistical and performance information related to acute care patient flow.

## Finding

21. Only one of the four hospitals that we examined, the Health Sciences Centre, had a structured reporting tool, a "scorecard", that was provided to senior management on a regular basis with statistical and performance information to effectively monitor actual results against benchmarks for key performance indicators. Western Memorial Regional Hospital, Central Newfoundland Regional Health Centre and Labrador Health Centre prepared scorecards but they provided limited statistical and performance information related to acute care patient flow.

***Bed Management Information Systems***

Real-time bed state is a crucial element of bed management, enabling hospital staff to better match demand and capacity and reduce the length of a patient's stay in the emergency department. A well-designed electronic system would provide hospital staff, in real time, with information on:

- occupancy rates;
- bed types, location and availability;
- patient location and status;
- admission information;
- patients held in emergency department; and
- elective surgery schedules.

Information systems should also be in place to capture and monitor housekeeping duties as it relates to the cleaning of beds. Our audit identified the following:

- All four hospitals that we examined use a web-based software program known as Cognos that downloads live information from the hospitals' Meditech systems. HSC and WMRH use Cognos extensively which provides statistics and information for managing acute care

beds. Although LHC and CNRHC have access to Cognos it is mainly used to produce financial information and is not used extensively to manage beds. LHC have manual processes for managing their 25 acute care beds, however, manually processing statistics can be time consuming and limit the assessment of performance indicators.

- Since March 2015, CNRHC used a web-based software program known as "Bed Manager". The system downloads live information from Meditech that creates a variety of statistics, reports and charts that can be accessed by staff to monitor bed capacity and discharges. As of September 2015, all staff were not yet trained and the system was not set up to provide historical reports for trend purposes.

- Electronic bed boards are a useful management tool and provide bed managers and unit staff with a particular unit's bed information including bed capacity, bed usage, patient names, length of stay, and notes on patients in emergency and day surgeries. The electronic bed boards are available online or are emailed twice to applicable staff throughout the day. Three of the four hospitals that we examined used electronic bed boards with the exception of LHC. The four hospitals also provided a patient census report daily which listed all patients assigned a bed including their current length of stay.

- Once a patient is discharged, it is important that beds are cleaned in a timely manner to ensure admitted patients can be placed in a bed. Hospitals should have either a manual or an electronic system in place to monitor the scheduling and cleaning times of beds. HSC was the only hospital that had an electronic monitoring system in place that provided information on cleaning times per employee and wait times once notification was received of a patient's discharge. WMRH and LHC did not have an information system to track and monitor the cleaning of beds. CNRHC tracked bed cleaning times manually for the purpose of employee performance daily but did not compile this information for statistical monitoring.

## Finding

22. Although all four hospitals that we examined used information systems and tools to manage acute care beds and track and monitor results, certain hospitals did not fully utilize these systems. We found that:

    - Central Newfoundland Regional Health Centre's newly implemented bed manager system could not provide historical trend reports;

    - Labrador Health Centre did not use electronic bed boards, which are used to report the status of beds to responsible staff; and

    - Western Memorial Regional Hospital and Labrador Health Centre did not have an information system to track and monitor the cleaning of beds and Central Newfoundland Regional Health Centre did not compile the information for statistical monitoring.

**Repatriation Agreements**

On occasion, patients are transferred from one hospital to a second hospital to avail of specialized skills at that hospital. The HSC is primarily the hospital that receives most transfer patients. Once the required procedure is complete, and the patient still requires acute care services, the patient is transferred back to the originating hospital. A delay in returning transferred patients to the originating hospital may result in bottlenecks with acute care patient flow. If capacity issues exist with the originating hospital, patients may not be transferred back on a timely basis which then creates capacity issues at the second hospital. This affects the ability of the second hospital to accept more patient transfers or meet their own acute care demands. In addition, increased capacity issues at the originating hospital are created, as patients awaiting transfer have to wait.

Best practice provides that hospitals enter into a repatriation agreement which requires that a transferred patient be accepted back by the originating hospital once the patient's acute care treatment is finished. None of the four hospitals that we examined had a formal repatriation agreement in place governing transferred patients. All RHAs had repatriation agreements in place with out-of-Province hospitals that required the RHAs to accept the patient back without delay after the patient was finished their treatment.

## Finding

23. Regional Health Authorities did not enter into repatriation agreements with one another to ensure that transferred patients are transferred back to the originating hospital once the patient's acute care treatment is finished at the second hospital and the patient still requires further acute care services. This may cause delays in patient transfers and create bottlenecks in the acute care system.

**Patient Satisfaction**

A complaints and occurrence reporting process and patient/family surveys would assist RHAs in identifying areas for improvement, required change to policies, procedures and processes, and monitoring patient care.

- All four hospitals that we examined had a patient complaint policy and process.

- All four hospitals that we examined had an occurrence incidents reporting process in place and had incident databases available. Only three hospitals were able to provide us with reported incidents related to acute care bed management. LHC did not code incidents specifically as acute care bed management issues, therefore, they were unable to provide us with specific occurrences.

- Three of the four hospitals that we examined conducted patient satisfaction surveys. LHC did not conduct a patient satisfaction survey.

## Findings

24. All four hospitals that we examined had a complaints process in place.

25. All four hospitals that we examined had an occurrence reporting process in place.

26. Three of the four hospitals that we examined completed patient satisfaction surveys. Labrador Health Centre did not have a patient satisfaction survey completed.

## D. Actual Results versus Performance Benchmarks

### Introduction

The timely comparison of actual results to established benchmarks for key performance indicators is an important tool in determining how well hospitals are performing and whether improvements are needed. Our audit included an examination of actual results against established benchmarks for certain performance indicators that related to acute care patient flow.

### Bed Occupancy

Acute care bed occupancy measures the actual bed utilization of a patient health facility for a given time period. Occupancy rates can be calculated by facility and/or by specific patient units and usually cover a specified period of time (month, year). The National benchmark for acute care bed occupancy is 85%. Meeting this benchmark would allow for available beds for emergency patients and still maintain good patient flow. Occupancy rates above 85% may result in insufficient availability of beds causing cancelled surgeries, patients having to wait in the emergency department, recovery room, and hallways, or the use of co-gender rooms or inappropriate rooms/wards.

Table 3 provides bed occupancy rates for the four hospitals we examined.

**Table 3**

**Regional Health Authorities**
**Acute Care Bed Management**
**Bed Occupancy Rates by Unit**
**For the Years Ended March 31**

| Hospital Unit | HSC | WMRH | CNRHC | LHC |
|---|---|---|---|---|
| Alternate Level of Care | Note 1 | 99% | 100% | Note 1 |
| Surgery (Note 2) | 97% | 91% | 88% | Note 1 |
| Medicine (Note 2) | 101% | 95% | 99% | Note 1 |
| Mental Health | 88% | 84% | 89% | Note 1 |
| 5SA Cardiology Unit | 95% | Note 3 | Note 3 | Note 3 |
| ICU | 87% | 101% | 82% | Note 1 |
| Obstetrics | 68% | 40% | 54% | Note 1 |
| **Total 2015** | **96%** | **93%** | **92%** | **91%** |
| **Total 2014** | **93%** | **95%** | **92%** | **91%** |
| **Total 2013** | **92%** | **92%** | **96%** | **Not available** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).
Note 1: The hospital does not have a separate unit for these patients.
Note 2: A medicine or ALC patient may be located in a surgery unit or ALC patient may be located in a medicine unit.
Note 3: The hospital does not provide cardiac surgery as an acute care service.

All four hospitals that we examined had overall occupancy rates in excess of 90% for the year ended March 31, 2015, ranging from 91% for LHC to 96% for HSC. Occupancy rates for certain units exceeded 100% which resulted in overcapacity for these units.

High occupancy rates can have a negative impact on emergency services, therefore, it is important that occupancy rates are kept at optimum levels so that capacity constraints do not arise. A large percentage of admissions originate from the Emergency Department. For the year ended March 31, 2015, admissions from the Emergency Department ranged from 45% for HSC to 62% for LHC.

The average wait time from Emergency Department to an acute care bed is another performance indicator of efficient patient flow. The National benchmark for an admitted patient to wait in the Emergency Department before being transferred to a bed, once the decision to admit has been made, is eight hours. If a patient admitted through the Emergency Department does not get timely access to a bed it creates access issues in the Emergency Department and may affect the level of care.

Table 4 shows average wait time from Emergency Department to a bed for the period from January 2015 to September 2015.

**Table 4**

**Regional Health Authorities**
**Acute Care Bed Management**
**Emergency Department Wait Times**
**From January 2015 to September 2015**

| Hospital | Wait Time |
|---|---|
| HSC<br>- Weekdays and Sunday<br>- Saturday | <br>10 hours<br>16 hours |
| WMRH | 106 minutes |
| CNRHC | 8 hours - not tracked by day |
| LHC | Not tracked |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

Our audit identified the following:

- Two of the four hospitals (WMRH and CNRHC) that we examined placed patients that were admitted through the Emergency Department in an acute care bed within the National benchmark of eight hours. WMRH utilized overflow beds adjacent to the Emergency Department and in the recovery room to support the admission of patients to an inpatient unit, whereas CNRHC measured it performace indicator from the time of admission to the transfer of the patient to a ward floor.

- Patients admitted through the Emergency Department at the HSC were not placed in an acute care bed within the National benchmark of eight hours.

- LHC did not capture actual results for this performance indicator.

## Findings

27. All four hospitals that we examined had bed occupancy rates higher than the National benchmark of 85%. For 2015, the overall bed occupancy rates at the four hospitals that we examined ranged from 91% to 96%.

28. Patients admitted through the Emergency Department at the Health Science Centre were not placed in an acute care bed within the National benchmark of eight hours. The Labrador Health Centre did not capture actual results for this performance indicator.

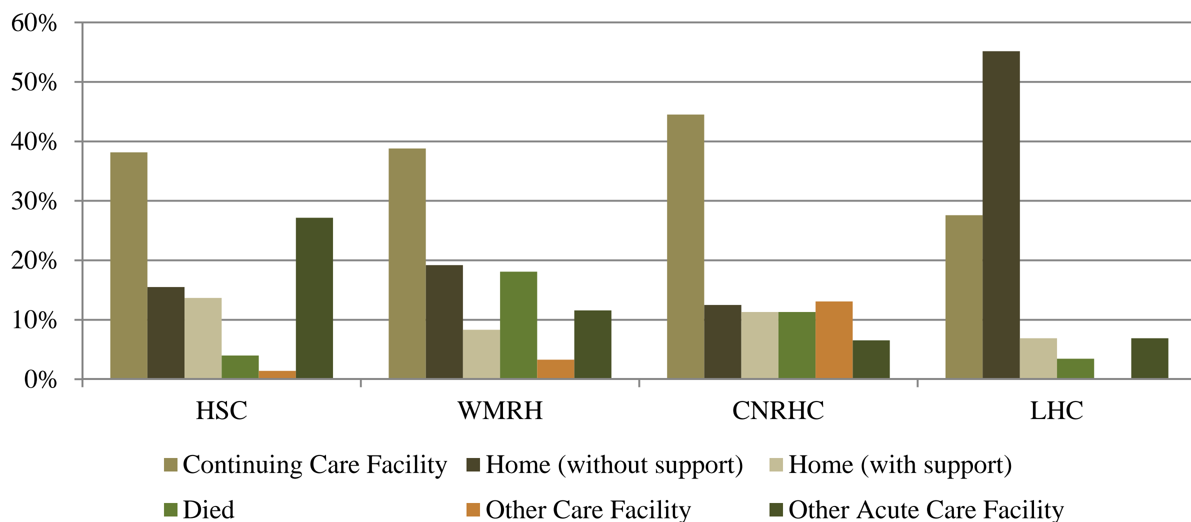
## Alternate Level of Care Patients

Alternate level of care (ALC) patients are those who have finished the acute care phase of treatment but remain in an acute care bed and are waiting for an appropriate level of care to meet their needs. ALC patients should be treated outside an acute care hospital such as in a long term care facility. Waiting for appropriate levels of care could impact patient flow, access to care, system integration, and availability of care and service options, system capacity and resources.

Chart 1 shows the discharge destinations for ALC patients at each of the four hospitals that we examined for the year ended March 31, 2015.

**Chart 1**

**Regional Health Authorities**
**Acute Care Bed Management**
**ALC Discharge Destinations by Percentage of Total ALC Discharges**
**For the Year Ended March 31, 2015**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

ALC patients were kept in acute care beds while either waiting for placements in long-term care facilities or personal care homes, waiting to go home, waiting for transfers to other acute care facilities and/or waiting for other non-acute care services. Due to the high number of ALC patients waiting for placement at long-term care (LTC) facilities at WMRH and CNRHC, separate ALC units were renovated to centralize and improve the quality of life and care that is more suitable for these long-term care residents.

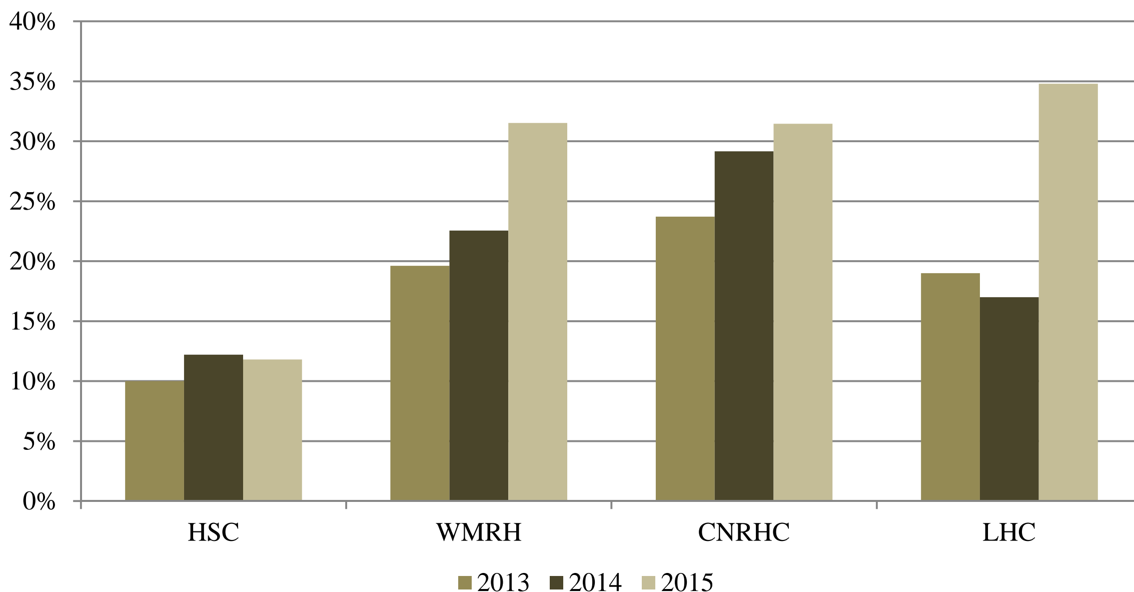
When acute care beds are used for alternate levels of care, hospital occupancy increases and patients may have to wait in emergency departments, hallways or recovery rooms while waiting for access to a bed.

The rate of ALC patient days as a percentage of total patient days is an important indicator of health system performance. In an efficient and effective acute care health environment, the percentage of ALC patient days to total patient days should be zero, as acute care beds should be strictly used for acute care purposes. However, given the nature and extent of ALC patients within the acute care environment, hospitals throughout Canada have established benchmarks and targets that are above zero. For example, HSC has established a benchmark of 8% with a target of 10% for the year ended March 31, 2015.

Chart 2 provides the percentage of ALC patient days to total patient days for each of the hospitals we examined.

**Chart 2**

**Regional Health Authorities**
**Acute Care Bed Management**
**Percentage of ALC Patient Days to Total Patient Days by Year-end and by Hospital**
**Years Ended March 31**



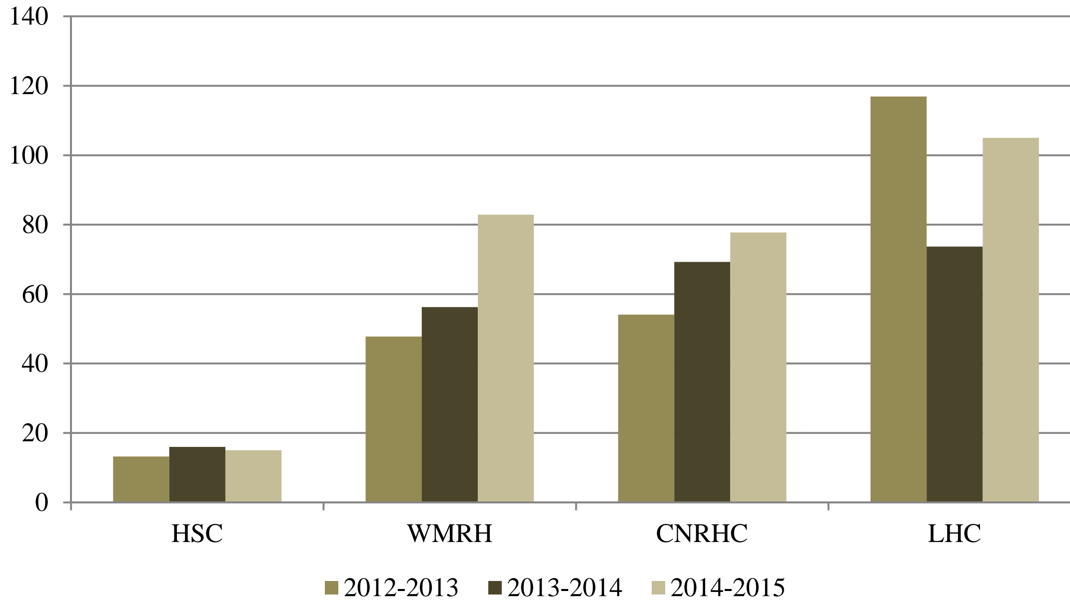

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

For the year ended March 31, 2015, the ALC patient days to total patient days ranged from a low of 12% for HSC to in excess of 30% at CNRHC, WMRH and LHC. Overall, the percentage of ALC patient days for all four hospitals has increased since 2013.

Chart 3 shows the average length of stay for ALC patients upon discharge.

**Chart 3**

**Regional Health Authorities**
**Acute Care Bed Management**
**ALC Patient - Average Length of Stay in Days by Year-end and by Hospital**
**Years Ended March 31**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

The average length of stay for an ALC patient ranged from 15 days at HSC to 105 days at LHC for the year ended March 31, 2015. Three of the four hospitals reported an average ALC length of stay in excess of 77 days for the year ended March 31, 2015. Since 2013, the average length of stay for ALC patients at three of the four hospitals that we examined has increased.

## Findings

29. All four hospitals that we examined had acute care beds being occupied by Alternate Level of Care patients that did not require acute care services. For three of the four hospitals that we examined (Health Science Centre, Western Memorial Regional Hospital and Central Newfoundland Regional Health Centre) the majority of Alternate Level of Care patients were waiting for continuing care placements in long-term care facilities or personal care homes. For the year ended March 31, 2015, the percentage of Alternate Level of Care patient days to total patient days ranged from a low of 12% for Health Science Centre to in excess of 30% at Central Newfoundland Regional Health Centre, Western Memorial Regional Hospital and Labrador Health Centre.

30. The average length of stay of Alternate Level of Care patients at three of the four hospitals that we examined was high. For the year ended March 31, 2015, the Alternate Level of Care average length of stay for Central Newfoundland Regional Health Centre, Western Memorial Regional Hospital and Labrador Health Centre was in excess of 77 days.

**Length of Stay**

The Canadian Institute for Health Information (CIHI) calculates and provides an expected length of stay (ELOS) which is an estimation of the typical average acute care length of stay for a patient visit. The ELOS is calculated by Case Mix Groups (CMGs) which is a Canadian patient classification system based upon the most responsible diagnosis. Comparing a patient's average length of stay (ALOS) to the ELOS is a key performance measurement.

Table 5 and Table 6 shows a comparison of ALOS to the ELOS for the top five CMGs for medicine and surgery, as provided by each of the four hospitals, for the period January 2015 to September 2015.

**Table 5**

**Regional Health Authorities**
**Acute Care Bed Management**
**ALOS Compared to ELOS**
**Weighted Average of the Top Five Medicine CMGs**
**January 2015 to September 2015**

| Hospital | # of cases | ALOS (Days) | ELOS (Days) | Variance (Days) | Total Additional Patient Days |
|---|---|---|---|---|---|
| HSC | 668 | 7.51 | 8.00 | (0.49) | (327) |
| WMRH | 617 | 10.80 | 7.05 | 3.75 | 2,314 |
| CNRHC | 332 | 10.98 | 7.00 | 3.98 | 1,321 |
| LHC | 126 | 3.35 | 4.03 | (0.68) | (86) |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

**Table 6**

**Regional Health Authorities**
**Acute Care Bed Management**
**ALOS Compared to ELOS**
**Weighted Average of the Top Five Surgery CMGs**
**January 2015 to September 2015**

| Hospital | # of cases | ALOS (Days) | ELOS (Days) | Variance (Days) | Total Additional Patient Days |
|---|---|---|---|---|---|
| HSC | 1,343 | 6.71 | 6.06 | .65 | 873 |
| WMRH | 398 | 3.12 | 2.67 | .45 | 179 |
| CNRHC | 154 | 3.36 | 3.34 | .02 | 3 |
| LHC | 41 | 2.19 | 2.34 | (.15) | (6) |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited).

For the four hospitals that we examined, two hospitals reported ALOS that exceeded the ELOS for the top five CMGs for medicine and surgery for the period January 2015 to September 2015. For medicine, the ALOS exceeded the ELOS by 3.75 days for WMRH and 3.98 days for CNRHC. For surgery, the ALOS exceeded the ELOS by 0.45 days for WMRH and 0.65 days for HSC.

## Finding

31. For the four hospitals that we examined, two hospitals reported average lengths of stay that exceeded the National expected lengths of stay for identified acute care treatments for medicine and surgery for the period January 2015 to September 2015. For medicine, the average lengths of stay exceeded the expected lengths of stay by 3.75 days for Western Memorial Regional Hospital and 3.98 days for Central Newfoundland Regional Health Centre. For surgery, the average lengths of stay exceeded the expected lengths of stay by 0.45 days for Western Memorial Regional Hospital and 0.65 days for Health Science Centre.

**Ambulatory Care Sensitive Conditions (ACSC)**

Proper bed management ensures that acute care patients are not admitted to a hospital bed when alternate health care options are available. Patients that have Ambulatory Care Sensitive Conditions (ACSC) such as epilepsy, chronic obstructive pulmonary disease, asthma, heart failure and pulmonary edema, hypertension, angina and diabetes have been identified by CIHI as patients where alternate health care options may be available other than being admitted. For patients younger than 75 years old, CIHI's benchmark for the year ended March 31, 2015 is that admissions should be limited to 331 ACSC patients per 100,000 population.

Table 7 provides the number of ACSC patients per 100,000 population for each of the four RHAs for the years ended March 31, 2013, 2014 and 2015.

**Table 7**

**Regional Health Authorities**
**Acute Care Bed Management**
**Ambulatory Care Sensitive Conditions (ACSC) Admissions per 100,000 Population**
**Years Ended March 31**

| RHA | 2013 | 2014 | 2015 |
|---|---|---|---|
| Eastern | 386 | 381 | 457 |
| Western | 540 | 496 | 573 |
| Central | 391 | 376 | 412 |
| Labrador - Grenfell | 465 | 450 | 531 |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from CIHI website (unaudited).

All four RHAs were admitting ACSC patients well above the National average. This will have a negative impact on the availability of acute care beds, and will create capacity issues in the health care system.

## Finding

32. All four Regional Health Authorities admitted patients with Ambulatory Care Sensitive Conditions above the National benchmark for these types of patients.

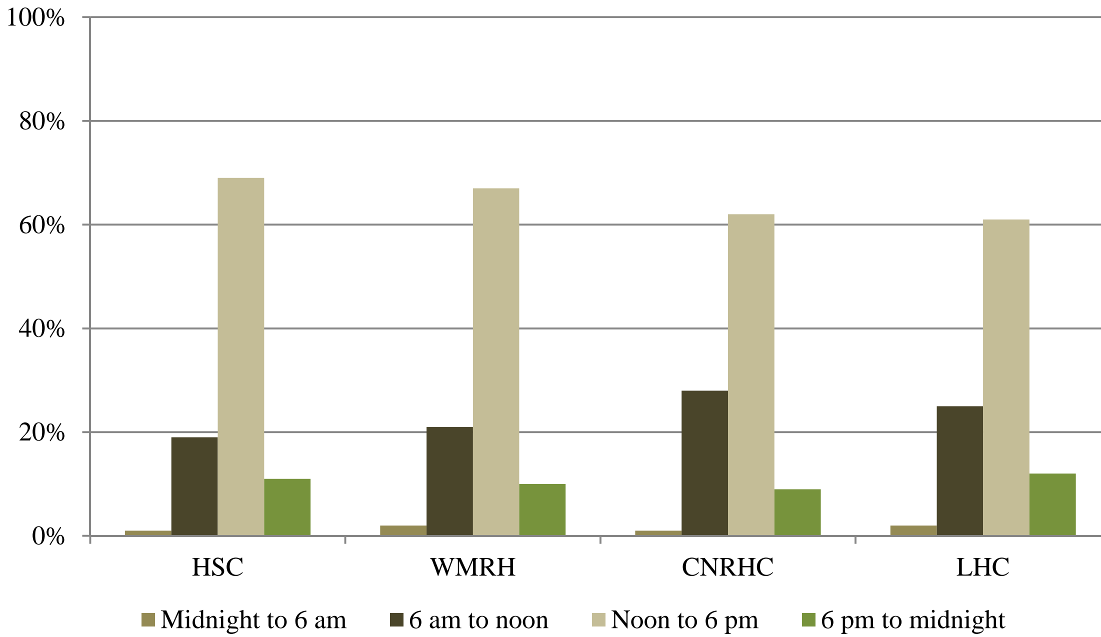
**Time and Day of Discharges**

Admission bottlenecks are often created because discharges are not managed efficiently. Creating a more consistent and predictable discharge schedule can help improve flow. This can be accomplished by scheduling the date and time that patients will be discharged at least one day in advance. Best practice indicates that patients should be discharged evenly throughout the week in the morning. Eastern RHA's and Labrador-Grenfell RHA's policy is to have patients discharged by 11:00 a.m. Western RHA implemented an 11:00 a.m. discharge strategy in 2004, however, it was ceased in 2005, as it was found to be unsuccessful. Western RHA's strategy is to vary discharges throughout the day and align them with the timing of admissions. Central RHA's discharge policy does not address the timing of discharges.

Chart 4 shows the timing of discharges for each of the four hospitals.

**Chart 4**

**Regional Health Authorities**
**Acute Care Bed Management**
**Discharge Times**
**January 2015 to September 2015**
**Percent per six hours**



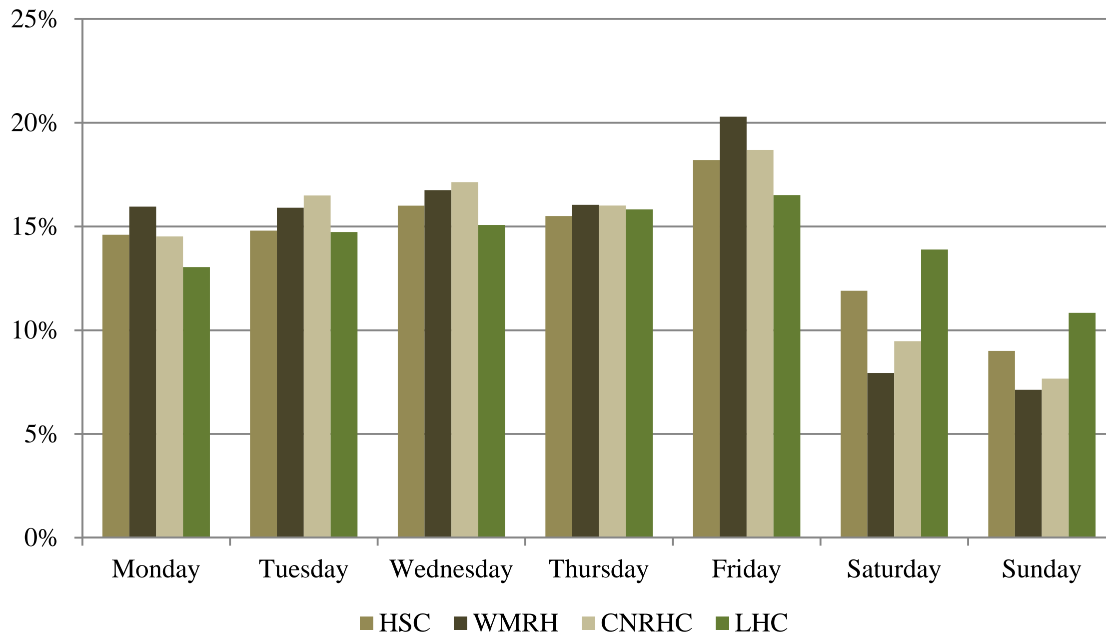

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited)

All four of the hospitals that we examined were not discharging the majority of their patients during the morning. All four hospitals had the highest discharge rates from noon to 6:00 p.m., ranging from 61% (LHC) to 69% (HSC) with only 19% (HSC) to 28% (CNRHC) being discharged between 6:00 a.m. and noon.

Chart 5 shows the average discharges per day of week for the four hospitals that we examined.

**Chart 5**

**Regional Health Authorities**
**Acute Care Bed Management**
**Discharge Days**
**January 2015 to September 2015**
**Percent per Day**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from RHAs (unaudited)

Of the four hospitals that we examined, patients were not being discharged on weekends at the same rate as during the week. All four hospitals had the highest discharge rates on a Friday with the lowest discharge rate on Sunday. Interviews with hospital officials indicated that the low level of discharges on weekends is a result of lower staffing levels available, reduced operating room activity, referral services not being available on weekends and handover of attending physicians for weekend coverage.

## Findings

33. All four hospitals that we examined were not discharging patients during the morning, consistent with best practice. 61% to 69% of patients were being discharged from noon to 6:00 p.m.

34. Best practice recommends that discharges should be distributed evenly throughout the week. All four hospitals that we examined were not discharging patients on weekends at the same rate as weekday discharges.

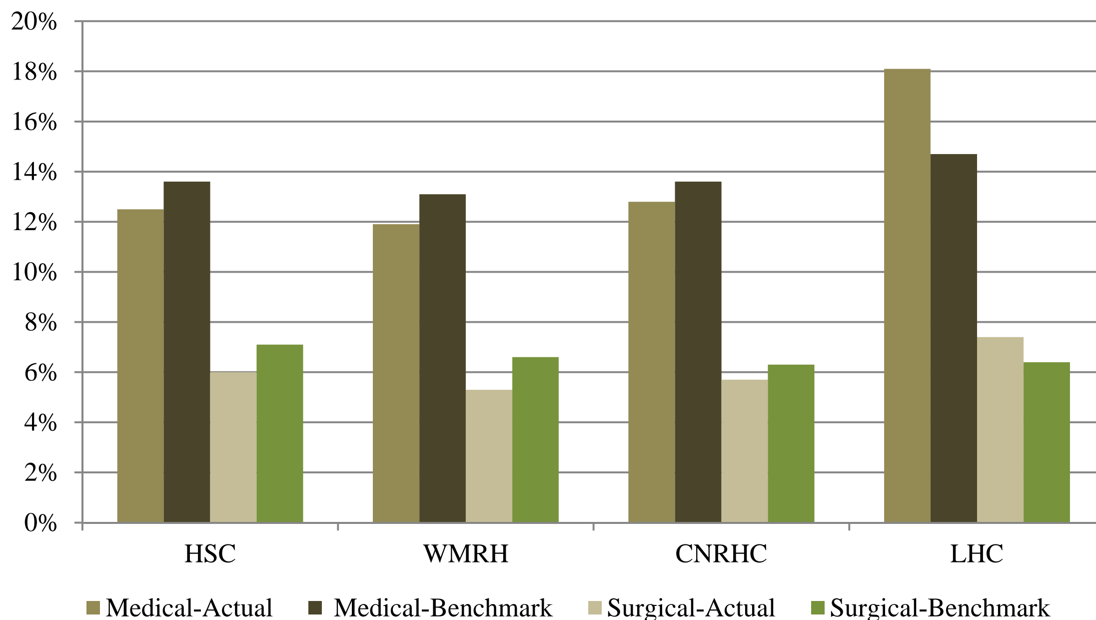
**Readmission Rates**

The rate of hospital readmissions is an indicator of how well various parts of the health system work together. Depending upon the hospital type and size, CIHI's benchmarks for readmission rates within 30 days, ranged from 6.3% to 7.1% for surgical patients and 13.1% to 14.7% for medical patients.

Chart 6 provides the readmission rates for surgical and medical patients compared to CIHI's benchmark.

**Chart 6**

**Regional Health Authorities**
**Acute Care Bed Management**
**Patient Readmission Rates within 30 Days**
**For the Year Ended March 31, 2015**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data from CIHI website (unaudited).

For the year ended March 31, 2015, one of the four hospitals we examined, LHC, exceeded the National readmission rate for medical patients with a readmission rate of 18.1% compared to the benchmark of 14.7% for small community hospitals. In addition, one of the four hospitals we examined, LHC, exceeded the National readmission rate for surgical patients with a readmission rate of 7.4% compared to the benchmark of 6.4% for small community hospitals. High readmission rates may be the result of a number of factors including a patient's health, the patient being discharged too early or the level of care provided while in the hospital or post discharge.

## Finding

35. One of the four hospitals (Labrador Health Centre) that we examined had a readmission rate for surgical and medical patients that were above the National benchmark for such readmissions.

### E. Implementation of Action Plans and Strategies

**Introduction**

In order to address deficiencies identified when performance benchmarks are not met, RHAs should develop strategies and action plans to improve performance. Each RHA has and continues to develop and implement various strategies to mitigate identified admission, discharge and overcapacity issues. However, it may take time to see significant improvement as a result of these strategies.

The following are examples of some strategies and action plans that were implemented during 2014-2015 by the four hospitals we examined to improve patient flow:

*Strategies to reduce unnecessary admissions*

- Community Rapid Response Team was a project at four hospitals – HSC, St. Clare's Mercy Hospital, WMRH and CNRHC. The plan was to provide an enhanced level of care for seniors in their homes in order to reduce inappropriate hospital admissions or reduce their length of stay in the hospital.

- A Remote Patient Monitoring pilot program for patients with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) was established at the Eastern RHA. Western RHA and Central RHA also implemented a pilot program for patients with COPD.

- WMRH, CNRHC and LHC have a chronic disease self-management coordinator that provides training for master trainers to go into the community and teach clients self-management care.

*Strategies to reduce wait times*

- "Pulling patients" to unit beds instead of having emergency department staff call the unit nursing staff to find out if there is a bed available was encouraged at HSC and CNRHC.

*Strategies to reduce length of stays (including ALC patients)*

- Lean Methodology methods were implemented at HSC, WMRH and CNRHC that examined hospital processes from a patient perspective with the goal of developing continuous improvement to support organizational efficiency and quality patient care.

- A clinical utilization review was completed at HSC for applicable clinical programs which outlined action plans to decrease the percentage of patients exceeding ELOS.

- Nurse practitioners were approved to discharge patients at HSC.

- All four hospitals encouraged their surgical units to use criteria-led discharges to improve the timeliness of discharges at least one day in advance.

- In July 2015, CNRHC implemented smoothing the number of elective scheduled surgery cases and case hours per working day.

- Reasons for non-compliance with ELOSs are documented. Staff at HSC do document transfer delays from Intensive Care Unit and the Operating Room.

- Patient Order Sets, which are a standardized list of treatments for patients with specific conditions, are in the process of being implemented at all four hospitals that we examined.

- Eastern RHA's Home First Pilot Program provided an opportunity for ALC patients waiting for long-term care placement to be discharged home with supports while waiting for placement.

## Finding

36. All four hospitals that we examined have implemented a number of strategies and action plans to improve patient flow as it relates to acute care bed management. Issues with bed availability, occupancy rates, non-acute care admissions and hospital stays, extended lengths of stay, discharges and readmissions have been identified within each Regional Health Authority, requiring their continued efforts.

# Recommendations

1. Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.

2. Regional health authorities should develop acute care bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.

3. Regional health authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patient rooms, early discharge times, patient transfer/repatriation protocols, and information systems that promote good planning and monitoring of acute care bed usage/availability.

4. Regional health authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.

## Eastern Regional Health Authority's Response

*Eastern Health (EH) has reviewed the findings as reported in the Acute Bed Management Report of the Auditor General (AG Report) that are applicable to Eastern Health RHA. These findings are not unfamiliar to EH and as such have formed much of the patient flow and bed management work undertaken by the EH over the past years. As requested, the following is the EH response and action plan to address specifically the four recommendations as cited in the AG Report.*

***Recommendation 1: Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.***

*EH has developed action plans to address patient flow including focusing on acute bed management and monitoring performance indicators such as discharge times by hours and day of week, length of stay comparisons for ALOS/ELOS, alternate level of care days and wait time in the ED from decision to admit to depart ED. These are just a few of the performance indicators that EH monitors and reports on a regular basis as referenced in your report. The performance targets established are based on achievable outcomes with progressive action plans to achieve national benchmarks. As an example, the EH Patient Flow Task Force was established in 2015 by the CEO to address patient flow and is focusing on 3 areas with established targets for achievement specifically related to a reduction in ALC days; reduction in percentage of typical patients exceeding the ELOS and reduction in the wait time from decision to admit to depart the ED.*

***Recommendation 2: Regional health authorities should develop acute care bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.***

*The focus for EH in reference to this will be in keeping with currently process improvement projects as directed by the Patient Flow Task Force. These are related to discharge time improvements to target as established by units; reviewing compliance with and updating current policies related to management of alternate level of care patients such as the First Available Bed Policy; compliance with transfers of admitted patients from ED to assigned bed within 30 minutes; and education of health care teams on appropriate admissions and length of stay targets.*

***Recommendation 3: Regional health authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patients rooms, early discharge times, patient transfer/repatriation protocols, and information systems that promote good planning and monitoring of acute care bed usage/availability.***

*As cited in the AG report, EH has implemented many of the bed management processes and systems however consistency in utilization of these varies across sites. EH will focus the work over the next year through monitoring of the guidelines for transfer of information as a Required Organizational Practice for Accreditation in 2017, 1) the utilization of the white boards as communication tool for patient, families and the health care team; 2) standardize the information on the boards across sites and monitor compliance with completion through auditing processes currently in place on inpatient units; and 3) increasing attendance by the entire health care team at bed huddles.*

*EH is willing to participate in a facilitated discussion by the Department of Health and Community Services with the provincial RHAs to develop repatriation agreements to ensure that the tertiary center is able to provide the necessary level of care in a timely manner to the secondary sites.*

***Recommendation 4: Regional health authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.***

*The reporting and monitoring of statistical program based information is shared within EH with the program leadership teams. Information is also readily available from COGNOS and Decision Support for senior management and teams. For the 2016/17 year, Decision Support will focus on report cards for the Patient Flow Task Force priorities related to ALC days, ED wait times and comparison of ALOS to ELOS. National comparators and standards will be identified to ensure best practice.*

*Patient flow and acute bed management has been a focus for EH senior leadership teams due to the high demand for access to the tertiary services provided within our programs. As such, process improvements to achieve the balance between capacity and demand are temporarily implemented and results achieved through team based work. Sustaining improvements will be the focus for the upcoming year within EH, with a continued focus on developing further improvements through LEAN Theory based approaches.*

## Western Regional Health Authority's Response

*Western Health is appreciative of the Office of the Auditor General's (OAG) review of acute care bed management and recommendations to improve patient flow. Western Health is committed to continue to work with the Department of Health and Community Services (DHCS) as well as the other Regional Authorities (RHAs) to ensure effective and efficient processes in admitting and discharging acute care patients from hospital.*

*In response to the recommendations outlined in the OAG report, Western Health would like to provide the following comments in relation to the recommendations.*

***Recommendation #1***

***Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.***

*As discussed in the OAG report, Western Health is tracking and monitoring eight of the nine identified indicators related to acute care bed management in keeping with best practice. These include bed occupancy, alternate level of care patient days, average number of patients admitted and discharged hourly and daily, percent of patients that exceed their expected length of stay (ELOS) by case mix grouping, percent of patients that exceed their ELOS by physician, ambulatory care sensitive conditions rate by RHA, emergency department wait time for a bed, and unscheduled readmission rate. It was noted that time to clean beds is currently not monitored by Western Health. While Western Health has a system in place to support notification and scheduling to ensure beds are cleaned, the RHA acknowledges that there is opportunity to capture information on the time required to clean beds for the purpose of tracking and trending against the benchmark. Western Health has been exploring opportunities and will continue to work toward establishing processes to monitor this indicator.*

***Recommendation #2***

***Regional health authorities should develop acute care bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.***

*Western Health has numerous policies and procedures in place which encompass admission and discharge processes to support efficient patient flow in acute care. In addition, Western Health has finalized a regional patient flow through acute care policy which is currently in the process of being implemented. This policy outlines the responsibility of each team member in managing patient flow as well as the change in response as bed availability decreases in acute care at each facility in the region. Western Health will continue to explore opportunities to enhance existing policies and/or develop new policies and procedures to support effective acute care bed management.*

***Recommendation #3***

***Regional Health authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patient rooms, early discharge times, patient transfer/repatriation protocols and information systems that promote good planning and monitoring of acute care bed usage/availability.***

*As discussed in the OAG report, Western Health has a number of processes and systems established to support good planning and monitoring of acute care bed usage/availability. This includes bed meetings with the admission discharge manager, clinical managers and*

*housekeeping, bullet rounds with the manager and nursing staff on all inpatient units Monday to Friday and twice weekly multidisciplinary rounds. The admission discharge manager and clinical managers have real time access to electronic reporting that provides information related to bed availability on a regional level. There are electronic bed boards located in the inpatient units however; Western Health acknowledges that there is opportunity to improve the information provided through the bed boards to support decision making. There is also opportunity to explore extending processes that are occurring Monday to Friday to seven days/week.*

*As noted in the OAG report, the RHAs currently do not enter into transfer/repatriation agreements to ensure transferred patients return to the originating hospital once the patient's acute care treatment at the secondary hospital is complete and the patient continues to require acute care services. Western Health will work with the DHCS and other RHAs to develop and implement repatriation agreements.*

***Recommendation #4***

***Regional health authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.***

*Within Western Health, each program area has a scorecard which identifies key indicators that measure performance against national benchmarks and established organizational targets. These reports are monitored at least quarterly and shared with key stakeholders including front line staff, physicians, leadership, and senior executive. Western Health acknowledges that there is opportunity to further develop and enhance the sharing of action plans to address identified opportunities for improvement and updates on progress with monitoring actions to achieve established targets.*

***Summary***

*Western Health acknowledges the findings and recommendations as outlined in the OAG report. The organization will move forward with the actions identified to address the recommendations. Western Health will continue to work collaboratively with the DHCS, the other RHA's, as well as patients and families to improve current processes and ultimately enhance patient flow as it relates to acute care bed management.*

## Central Regional Health Authority's Response

*Central Health acknowledges the work of the Office of the Auditor General (OAG) in reviewing acute care bed management and proposing recommendations to improve patient flow. Central Health is committed to continuing to work with our counterparts in the other Regional Health Authorities (RHAs) and the Department of Health and Community to further advance our work in ensuring that our acute care bed management processes are as efficient and effective as possible.*

*In response to the recommendations outlined in the OAG report, Central Health would like to provide the following comments.*

***Recommendation #1***

***Regional health authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.***

*The findings discussed in the OAG report indicate that Central Health has identified and is tracking all but two of the recommended performance indicators related to acute care bed management. Central Health will add the two indicators that are not currently being measured to the Board Performance and Improvement Scorecard along with relevant benchmarks.*

*Hospital targets as outlined in the provincial report, A Strategy to Reduce Emergency Department Wait Times in Newfoundland and Labrador, have been included on the Board Performance Improvement Committee (BPIC) scorecard for two years. However, in the third quarter of 2015-16 it was recognized by the BPIC that additional targets for performance indicators were required to effectively monitor the acute care beds and flow from the Emergency Department. Targets were devised for the remaining indicators based on the data compiled with respect to program performance over the previous year.*

*Discussions are ongoing with respect to inclusion of national benchmarks and targets on the scorecard and the scorecard is consistently being adjusted to reflect the national benchmarks.*

***Recommendation #2***

***Regional health authorities should develop acute bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.***

*Three new bed management policies, Acute Bed Management, Overcapacity, and Client Repatriation, were developed and implemented in Central Health in January 2016. The objective of the Acute Bed Management Policy is to outline a standardized approach to efficiently manage and appropriately use acute care beds in all inpatient program areas to optimize patient flow from all admission points of entry (ED, operating rooms,*

*repatriation/transfer). The Overcapacity Policy provides a protocol to address the impedance of patient flow through the admission points of entry when there is 90% utilization of acute care beds. To manage patient flow on an everyday basis it is important to utilize all acute care beds in the region therefore the Client Repatriation Policy outlines a standardized approach and time frame for repatriating/transferring clients to an acute care facility near their residence or transferring to another acute care facility in Central Health. These standardized approaches support system flexibility and responsiveness by enhancing timely access to acute care services. The intent is to ensure that Central Health is able to best provide patient-centered services in ED while outlining a clear process to coordinate patient flow between the ED and the inpatient units and other facilities within Central Health.*

*The policies were disseminated to stakeholders to promote the full utilization of all regional acute care beds. Continued communication and reinforcement of the rationale for these policies with patients, families, staff and physicians is a priority for Central Health. To supplement the Client Repatriation policy the brochure, Transfer to Another Facility for Continued Care, was developed to provide to patients and their families upon admission. The purpose of this information pamphlet is to communicate and explain that a transfer to another facility in Central Health may be necessary as we strive to provide the right care, in the right place, at the right time.*

*Two other polices that have recently been revised and/or developed include Medical Discharge and Alternate Level of Care.*

*It is acknowledged that medication reconciliation is a significant patient safety initiative. Central Health has a multidisciplinary team with senior leadership support that has been working towards the implementation of medication reconciliation across all services. As the electronic pharmacy network becomes available to connect all pharmacies in the province and the electronic system for documenting best possible medication history and medication reconciliation is put in place, Central Health will be in a position to ensure compliance with the Required Organizational Practice from Accreditation Canada.*

*The documentation of an expected discharge date for admitted patients has not been a consistent practice followed by physicians in Central Health. A commitment from physician leadership to embark upon this improvement initiative will be essential. To begin this work, Central Health will commit to devising an action plan for policy development and deployment ensuring change management principles are integrated into this effort.*

*Central Health will continue to explore opportunities to improve our policy framework to support the acute care bed management process. This will be a collaborative effort between health information management, nurses, physicians and other key stakeholders.*

***Recommendation #3***

***Regional health authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patient rooms, early discharge times, patient transfer/repatriation protocols, and information systems that promote good planning and monitoring of acute care bed usage/availability.***

*Central Health, as acknowledged in the OAG report, currently has a number of processes in place to promote good planning and monitoring of acute care bed usage. Bed huddles are conducted at James Paton Memorial Regional Health Centre (JPMRHC) each weekday morning and, if required, the team regroups in the afternoon. At the Central Newfoundland Regional Health Centre (CNRHC), this practice was modified with meetings held on each of the individual units for patient flow updates and planning. Currently, the Director of Site Operations is working with the individual units at CNRHC to facilitate how best to reintroduce morning Bed Huddles in September 2016. Bed huddles are held on a much smaller scale on the weekends with the Site Coordinator taking a leadership role in managing the client flow. Conversations with respect to potential discharges, client repatriation or transfers are discussed prior to the weekend to devise the weekend plan.*

*The Bed Manager is a technological solution used to provide real time bed occupancy data in all the facilities in Central Health and is available to the Director of Site Operations and Site Coordinators. They can view the bed availability which helps to facilitate the necessary conversations to promote the utilization of all regional acute care beds to effectively mitigate overcrowding in the ED at the secondary sites.*

*Training in this technology has been provided for key stakeholders at CNRHC, JPMRHC and the rural sites to complete discharge assessments on all acute inpatients to determine and document discharge delays.*

*Reports have been developed in Bed Manager to display historical data and members of the Information Management and Technology Department are receiving training to generate a number of additional reports that will display client flow data. Efforts to enhance awareness and increase utilization of the Bed Manager tool and the available reports will be accompanied by a communication strategy and evaluation plan.*

*Central Health acknowledges that there is an opportunity to improve communication through the utilization of standardized whiteboard templates. An earlier proposal to potentially address the issue will be reviewed again in light of the recommendations in this report.*

***Recommendation #4***

***Regional health authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow-up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.***

*At Central Health, the work of the Board Performance Improvement Committee (BPIC) highlights a number of performance indicators and targets for client flow. This scorecard is reviewed by the senior leaders and board members after every quarter to monitor results and trends. The BPIC invites the different stakeholders to provide a presentation on the performance indicators monitored in their program area and the targets are reviewed along with the challenges and opportunities for improvements. Variances are identified and if follow-up is required, the BPIC members request the necessary information to be provided in a specified timeframe or the stakeholders return to present their improvement actions.*

*The scorecard is provided to physician leaders and managers to review and is available to all employees on the intranet. Central Health acknowledges that deployment of client flow indicators requires a more robust communication strategy and this will be actioned in future planning processes.*
*In addition to the scorecard, statistical reports are available on Bed Manager that provide trends for the previous twelve months. These reports are available to a number of managers, senior leaders and physician leaders. Information Management and Technology is currently working on initiatives to enhance reporting, trending and analysis to provide the comprehensive data needed to inform improvement work to enhance client flow.*

*As part of our long range planning process, Central Health had an external consultant study long term care (LTC) needs in the region and the study recommended the addition of a minimum of 34 new long term care beds in Grand Falls Windsor and 56 in Gander. This gap between existing and recommended beds has a significant impact on patient flow especially at the two secondary referral sites in the region.*

***Summary***

*Central Health acknowledges the findings and recommendations as set forth in the OAG report and is committed to moving forward with the appropriate actions to address the recommendations. Client flow is a priority issue for our organization has demonstrated in the selection of this issue as one of our three strategic directions for the organization. We look forward to further collaboration with our RHA and DHCS colleagues as we continue to advance this very important work.*

## Labrador-Grenfell Regional Health Authority's Response

*Labrador-Grenfell Health would like to express our appreciation to the Office of the Auditor General (OAG) on the review of Acute Care Bed Management, inclusive of the identification of deficiencies within the system and recommendations for improvement. Labrador-Grenfell Health will continue to work with the Department of Health and Community Services, the other Regional Health Authorities, clients and families to ensure that the recommended processes are implemented to enhance not only the quality of care we provide but for the efficient and effective functioning of the organization.*

*Please see following responses to recommendations 1, 2, 3 and 4 outlined in the OAG Report.*

***Recommendation # 1:***

***Regional Health Authorities should identify and/or establish performance indicators related to acute care bed management and ensure national benchmarks are identified or hospital targets are established for each performance indicator.***

*Labrador-Grenfell Health Response:*

*Labrador-Grenfell Health acknowledges that although we use information systems and tools to manage acute care beds track and monitor results, there is opportunity to enhance these systems to monitor key performance indicators allowing better management of acute care beds and patient flow. Labrador-Grenfell Health is committed to making improvements to our practices relating to acute care bed management within the region inclusive of electronic bed boards and a system to track cleaning. We have recently employed a data analyst/decision support position who duties will include compiling and interpreting performance indicators, designing and implementing systems to establish benchmark, compiling statistics, comparing results and identifying regional, provincial and national trends/variances related to bed management.*

***Recommendation # 2:***

***Regional Health Authorities should develop acute care bed management policies and procedures which encompass admission and discharge processes that are complete and comprehensive.***

*Labrador-Grenfell Health Response:*

*As discussed in the OAG Report Labrador-Grenfell Health has some policies in place regarding admission and discharge processes but they are not regionalized, complete or comprehensive in guiding staff in managing acute care beds effectively. Labrador-Grenfell Health is committed to enhancing existing policies and /or developing new policies and procedures to support effective acute care bed management.*

*Effective October 31, 2016, Labrador-Grenfell Health will be implementing a Post Discharge Call (PDC) program. This program is an evidence-based approach to decrease Labrador-Grenfell Health's readmission rates, which we anticipate will assist in attaining the national benchmark.*

***Recommendation # 3:***

***Regional Health Authorities should establish bed management processes and systems which include daily multidisciplinary meetings, daily bed huddles, electronic bed boards, posted and informative whiteboards in units and patient rooms, early discharge times, patient transfer/repatriation protocols and information systems that promote good planning and monitoring of acute care bed usage/availability.***

*Labrador-Grenfell Health Response:*

*As discussed in the OAG Report Labrador-Grenfell Health has a number of processes in place to support good planning and monitoring of acute care bed usage inclusive of staff meetings, bullet rounds with manager and nursing staff on the Inpatient Units and white boards to record patients expected discharge date. However, Labrador-Grenfell Health acknowledges that there is opportunity to improve and to extend our processes that occur Monday to Friday to seven days/week. As noted in the OAG Report the RHA's do not currently enter into a transfer/repatriation agreements to ensure that the transfer of patients to the originating hospital if the patient continues to require acute care services once the critical care has been provided. Labrador-Grenfell Health will work with the Department of Health and Community Services and the other RHA's to develop these agreements. Also noted, that at the time of the report, Labrador-Grenfell Health did not have a patient satisfaction survey process implemented. Since then Labrador-Grenfell Health has implemented a client satisfaction survey process entitled, Client Experience Survey.*

***Recommendation # 4:***

***Regional Health Authorities should compare actual results to established benchmarks and targets for key performance indicators, in order to identify variances that require follow up and action. Statistical and performance indicator reports should be provided to senior staff, bed managers and other interdisciplinary team members for effective planning and resource decisions.***

*Labrador-Grenfell Health Response:*

*As noted in the OAG report Labrador-Grenfell Health prepares a scorecard which identifies key indicators that measure performance against national benchmarks which is provided to Senior Management and the Board of Directors but has limited statistical information related to acute care patient flow. Labrador-Grenfell Health sees this as an opportunity for improvement and will further enhance the scorecard to include this indicator.*

# PART 3.4

# DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

# ROAD AMBULANCE SERVICES

# Summary


## Introduction

The road ambulance program is a critical component of the health care system.

The Department of Health and Community Services is responsible for policies, procedures, standards, and contract negotiations with private and community ambulance operators. The Regional Health Authorities are responsible for the day-to-day operations of the road ambulance program including oversight of private and community ambulance operations plus their own ambulance operations.

The Provincial Medical Oversight Program operates within the Eastern Regional Health Authority and provides medical oversight for all publicly subsidized ambulance services in the Province and is responsible for registration, certification and approving and tracking continuing education for ambulance attendants. In 2015 the Province had 769 registered ambulance attendants.

The Eastern Regional Health Authority operates its own ambulance service from base hospitals in St. John’s and Carbonear. The Eastern Regional Health Authority is also responsible for the oversight of the road ambulance services provided by 15 private operators and six community operators in the eastern region. In performing this oversight, the Eastern Regional Health Authority must ensure that these operators are adhering to the standards established by the Department of Health and Community Services and the contracts that are negotiated between the ambulance operators and the Department of Health and Community Services.

## Objectives

The objectives of our audit were to determine whether:

1. Road ambulance services provided by base hospitals and private/community operators for the Eastern Regional Health Authority have the appropriate skill levels required to provide quality care;

2. Road ambulance response times at the Eastern Regional Health Authority are meeting the needs of residents of the eastern region of the Province;

3. The Department of Health and Community Services exercises effective oversight of the Regional Health Authorities’ responsibilities in operating the road ambulance program; and

4. The Eastern Regional Health Authority has processes in place to effectively monitor the day-to-day operations of road ambulance services provided by base hospitals and private/community operators, and their compliance with the Department of Health and Community Services policy.

Criteria were developed specifically for this audit based upon relevant legislation, the Department of Health and Community Services and Eastern Regional Health Authority policies and procedures, reviews of literature including reports of other legislative auditors, and discussions with management. The criteria were accepted as suitable by the senior management of the Department of Health and Community Services and the Eastern Regional Health Authority.

## Scope

Our audit commenced in September 2015 and included the period from April 1, 2013 to September 30, 2015. Our audit focused on the operation of the road ambulance program in the eastern region of the Province.

Our audit included an examination of contracts between the Department of Health and Community Services, the Eastern Regional Health Authority and private and community operators, policies and procedures and the Ambulance Operations Standards Manual. We inspected a sample of patient records maintained by the Eastern Regional Health Authority. As well, we analyzed ambulance transport data to assist with our audit procedures. We conducted interviews with officials at both the Department of Health and Community Services and the Eastern Regional Health Authority. Our sample selections were non-statistical and random.

In order to determine the Canadian industry best practice for attendant skill level and ambulance response times we conducted research of the road ambulance services provided by the other provinces.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

Certain information in this report regarding road ambulance transports was compiled based on data reported by private and community ambulance operators. We have not verified the accuracy of this information.

We substantially completed our audit in March 2016.

## Importance to Newfoundlanders and Labradorians

The road ambulance program provides an essential service to the people of Newfoundland and Labrador. The skill level of ambulance attendants, response times, and effective governance and oversight are all critical in ensuring patients are provided with an appropriate standard of care. In many instances a road ambulance is the first point of contact for an individual in an emergency situation and the quality of care provided could have a direct impact on the outcome of the patient’s condition.

## Conclusions

**Objective 1**

Department of Health and Community Services policy requires a lower skill level for ambulance attendants than required by Canadian industry best practice.

Road ambulance services provided by the Eastern Regional Health Authority base hospitals have the appropriate skill levels required to provide quality care and is consistent with Canadian industry best practice.

Road ambulance services provided by private and community operators for the Eastern Regional Health Authority do not always have the skill levels required by Canadian industry best practice.

Road ambulance services provided by private operators for the Eastern Regional Health Authority do not always meet the skill levels required by the Department of Health and Community Services, which is lower than Canadian industry best practice.

**Objective 2**

The Eastern Regional Health Authority's hospital based ambulance service is not always meeting its response time benchmark for the metro St. John's region and, therefore, may not be meeting the needs of residents of the metro St. John's region.

The hospital ambulance operation in Carbonear is meeting the Canadian industry best practice response time benchmark for rural areas.

Not all private and community ambulance operators meet the Canadian industry best practice response time benchmark for rural areas and, therefore, may not be meeting the needs of rural residents of the eastern region.

**Objective 3**

The Department of Health and Community Services is not providing effective oversight of the road ambulance program.

**Objective 4**

The Eastern Regional Health Authority has some processes in place to monitor the day-to-day operations of the road ambulance services within its region; however, these processes are not effective in determining whether road ambulance services provided in the region are in compliance with Department of Health and Community Services policy.

## Findings

### Road Ambulance Attendant Skill Level

*Minimum Skill Level of Attendants*

1. The policy of the Department of Health and Community Services outlining the minimum skill level required for drivers and primary care givers on emergency road ambulance transports is outdated and does not reflect the current requirements of the road ambulance program.

2. The minimum skill level for ambulance attendants required by the Department of Health and Community Services on emergency road ambulance transports is less than Canadian industry best practice.

*Training and Continuing Education*

3. The Provincial Medical Oversight Program ensured that the registered ambulance attendants in the sample we examined had the required education and training consistent with their classification.

4. The Department of Health and Community Services does not require dispatchers to have a minimum level of training or to be registered through the Provincial Medical Oversight Program.

5. The Eastern Regional Health Authority requires the dispatchers it employs for its base hospital ambulance operations to be appropriately trained.

*Monitoring of Attendant Skill Level on Ambulance Transports*

6. The Eastern Regional Health Authority employs hospital ambulance attendants at a skill level that is consistent with Canadian industry best practice. This is a higher skill level than required by the Department of Health and Community Services.

7. The Eastern Regional Health Authority has processes in place to ensure that ambulance attendants reported on an ambulance transport are registered by the Provincial Medical Oversight Program.

8. Privately operated ambulance bases in the eastern region did not always have at least one Primary Care Paramedic on emergency transports. The policy of the Department of Health and Community Services requires the use of at least one Primary Care Paramedic on all emergency transports conducted by private operators.

9. The Department of Health and Community Services holds community operators to a lesser standard than private operators. It requires a Primary Care Paramedic or above on only 25% of ambulance transports. There is no difference between patients served by community operators and private operators. While all community operator bases in the eastern region were in compliance with Department of Health and Community Services policy, this was a lower standard than Canadian industry best practice and is a lower requirement than private operators.

10. The Ambulance Operations Standards Manual requires ambulance operators to make "best efforts" to ensure ambulance attendants have the required skills to work on an ambulance. Operators must submit a formal request to the Department of Health and Community Services for an exemption from the skills policy with evidence of the steps they have followed in an effort to recruit or upgrade staff. Despite the fact that private ambulance operators employ attendants with less than the required skill levels, neither the Department of Health and Community Services nor the Eastern Regional Health Authority had documentation for any requests for relief under the "Best Efforts" policy.

**Road Ambulance Response Times**

*Response Time Benchmarks*

11. The Eastern Regional Health Authority has established a ten minute ambulance response time benchmark for its own ambulance operations in the metro St. John's area. However, it has not established a response time benchmark for its Carbonear operations.

12. The Department of Health and Community Services and the Eastern Regional Health Authority have not set any ambulance response time targets for ambulance services outside the metro St. John's region.

*Monitoring and Assessment of Response Time Benchmarks*

13. The Eastern Health Regional Health Authority was not monitoring the hospital based ambulance service to ensure road ambulance transports were meeting the response time benchmark.

14. The hospital ambulance operations in the metro St. John's region are not always meeting the ten minute response time benchmark established by the Eastern Regional Health Authority.

15. The Eastern Regional Health Authority has not established a response time benchmark for its own ambulance operations in Carbonear. The hospital ambulance operation in Carbonear is meeting the Department of Health and Community Services chute time benchmark of 10 minutes, 90% of the time. It was also meeting the Canadian industry response time benchmark for rural areas of 15 minutes, 90% of the time.

16. The Eastern Regional Health Authority is not monitoring private and community operators to ensure road ambulance transports are meeting the chute time benchmark.

17. Patient Care Reports, which are prepared by ambulance attendants and are required to be included in the patient medical record, were missing in 82 of 100 patient files we examined.

18. Six of the Patient Care Reports that were available for examination had been altered after the patient transport was completed.

**Governance and Oversight Provided by the Department of Health and Community Services**

*Performance Objectives, Targets and Information Needs*

19. The Department of Health and Community Services has not established performance objectives or evaluation criteria for the road ambulance program, with the exception of chute time. This limits the ability of the Department of Health and Community Services to effectively monitor performance.

20. The Department of Health and Community Services has not established any reporting requirements for the Regional Health Authorities with regards to the operation of the road ambulance program.

*Communication of Expectations*

21. The Department of Health and Community Services has not communicated clearly defined performance objectives, targets or information needs to the Regional Health Authorities or the Provincial Medical Oversight Program for the road ambulance program.

22. The Department of Health and Community Services is not updating the policies and procedures and Ambulance Operations Standards Manual to reflect current practices.

23. In some instances, the policies governing the daily operations of the road ambulance program were not being enforced.

*Monitoring and Evaluation*

24. The Department of Health and Community Services does not monitor the road ambulance program to determine whether the intended results were achieved.

25. While the Department of Health and Community Services hired a consultant to review the road ambulance program, two years after the report was issued, none of the immediate term recommendations have been completed.

**Governance and Oversight Provided by the Eastern Regional Health Authority**

*Communication of Performance Expectations*

26. The Ambulance Operations Standards Manual and related policies and procedures are not conveyed to operators in an easy to follow format.

27. Despite the fact that policies and procedures are outdated the Regional Health Authorities have to rely on the Department of Health and Community Services to update and communicate these policies and procedures to ambulance operators. Regional Health Authorities are responsible for the day-to-day operations of the road ambulance program in their region; however, they have no ability to change policies and procedures.

28. Contract negotiations extended three years beyond the original expiry date of previous contracts between the Department of Health and Community Services, the Eastern Regional Health Authority and the private and community operators.

29. The Department of Health and Community Services does not seek the advice of the Regional Health Authorities when negotiating contracts with private and community ambulance operators despite the operational expertise that exists at the Regional Health Authorities.

*Performance Monitoring*

30. While the Eastern Regional Health Authority has some systems and processes in place to monitor the operations of road ambulance services provided by base hospitals, and private and community operators, these systems and processes do not monitor all aspects of the operations of the road ambulance program.

## Recommendations

1. The Department of Health and Community Services should evaluate its basis for road ambulance attendant skill level policy, which is below Canadian industry best practice, and determine whether it is sufficient to ensure quality care.

2. The Eastern Regional Health Authority should ensure that the road ambulance services provided by private and community based operators for the Eastern Regional Health Authority meet the skill levels required by the Department of Health and Community Services. In instances in which operators demonstrate that they must temporarily employ attendants with less than the required skill levels, the Eastern Regional Health Authority and the Department of Health and Community Services should ensure there is adequate documentation for relief under the “Best Efforts” policy.

3. The Department of Health and Community Services should ensure that its policies and procedures and the Ambulance Operations Standards Manual:

   - are up to date and reflect all requirements of the road ambulance program;
   - are being enforced; and
   - are conveyed to operators in an easy to follow format.

4. The Department of Health and Community Services should evaluate its basis for dispatcher training, and determine whether it is sufficient to ensure quality care.

5. The Department of Health and Community Services should set ambulance response time targets, giving consideration to Canadian industry best practice for response times.

6. The Eastern Regional Health Authority should ensure targets that the Department of Health and Community Services sets are being monitored for the eastern region of the Province.

7. The Eastern Regional Health Authority should ensure that Patient Care Reports are included in patient medical records and that the Patient Care Reports are not altered after the patient transports are completed.

8. The Department of Health and Community Services should ensure it is providing effective oversight of the road ambulance program, through the establishment and communication of clearly defined performance objectives and its information needs to the Regional Health Authorities and the Provincial Medical Oversight Program.

9. The Department of Health and Community Services should ensure that contracts with the private and community operators are negotiated and renewed in a timely manner and ensure that it seeks the advice of the Regional Health Authorities when negotiating the contracts.

10. The Department of Health and Community Services should monitor the road ambulance program to ensure intended results are achieved.

11. The Eastern Regional Health Authority should have systems and processes in place to effectively monitor the day-to-day operations of road ambulance services provided by base hospitals and private and community operators, and their compliance with Department of Health and Community Services policy.

## Importance of implementing these recommendations

The road ambulance program is a critical component of the health care system and provides an essential service to the people of Newfoundland and Labrador. An appropriate standard of care in the ambulance services of the Province requires attendant skill levels, ambulance response times and program governance and oversight that are meeting the needs of all residents served. Benchmarks and performance objectives for attendant skill levels and ambulance response times, and monitoring against those benchmarks and objectives, are critical areas of oversight to ensure the health care needs of the people of Newfoundland and Labrador are being met in emergency situations.

# Objectives and Scope

## Objectives

The objectives of our audit were to determine whether:

1. Road ambulance services provided by base hospitals and private/community operators for the Eastern Regional Health Authority (Eastern Health) have the appropriate skill levels required to provide quality care;

2. Road ambulance response times at Eastern Health are meeting the needs of residents of the eastern region of the Province;

3. The Department of Health and Community Services (the Department) exercises effective oversight of the Regional Health Authorities' (the RHAs') responsibilities in operating the road ambulance program; and

4. Eastern Health has processes in place to effectively monitor the day-to-day operations of road ambulance services provided by base hospitals and private/community operators, and their compliance with Department policy.

Criteria were developed specifically for this audit based upon relevant legislation, Departmental and Eastern Health policies and procedures, reviews of literature including reports of other legislative auditors, and discussions with management. The criteria were accepted as suitable by the senior management of the Department and Eastern Health.

## Scope

Our audit commenced in September 2015 and included the period from April 1, 2013 to September 30, 2015. Our audit focused on the operation of the road ambulance program in the eastern region of the Province.

Our audit included an examination of contracts between the Department, Eastern Health and private and community operators, policies and procedures and the Ambulance Operations Standards Manual (the Standards Manual). We inspected a sample of patient records maintained by Eastern Health.  As well, we analyzed ambulance transport data to assist with our audit procedures. We conducted interviews with officials at both the Department and Eastern Health. Our sample selections were non-statistical and random.

In order to determine the Canadian industry best practice for attendant skill level and ambulance response times we conducted research of the road ambulance services provided by the other provinces.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

Certain information in this report regarding road ambulance transports was compiled based on data reported by private and community ambulance operators. We have not verified the accuracy of this information.

We substantially completed our audit in March 2016.

# Background

The road ambulance program is a critical component of the health care system.

The Department is responsible for policies, procedures, standards, and contract negotiations with private and community ambulance operators. The RHAs are responsible for the day-to-day operations of the road ambulance program including oversight of private and community ambulance operations plus their own ambulance operations.

The Provincial Medical Oversight Program (PMO) operates within Eastern Health and provides medical oversight for all publicly subsidized ambulance services in the Province and is responsible for registration, certification and approving and tracking continuing education for ambulance attendants. In 2015 the Province had 769 registered ambulance attendants.

Eastern Health operates its own ambulance service from base hospitals in St. John's and Carbonear. Eastern Health is also responsible for the oversight of the road ambulance services provided by 15 private operators and six community operators in the eastern region. In performing this oversight, Eastern Health must ensure that these operators are adhering to the standards established by the Department and the contracts that are negotiated between the ambulance operators and the Department.

Total expenditures of Eastern Health for the eastern region of the road ambulance program for the 2015 fiscal year totaled $25.9 million.

**Table 1**

**Department of Health and Community Services**
**Road Ambulance Program – Eastern Region**
**Information by Service Provider Type**
**March 31, 2015**

| Road Ambulance Service Provider | Total expenditures ($000) | Number of Operators | Number of Ambulances | Number of Transports |
|---|---|---|---|---|
| Private operators | $15,516 | 15 | 59 | 21,957 |
| Base hospital operations | 8,648 | 2 | 16 | 25,831 |
| Community operators | 1,717 | 6 | 9 | 1,906 |
| **Total** | **$25,881** | **23** | **84** | **49,694** |

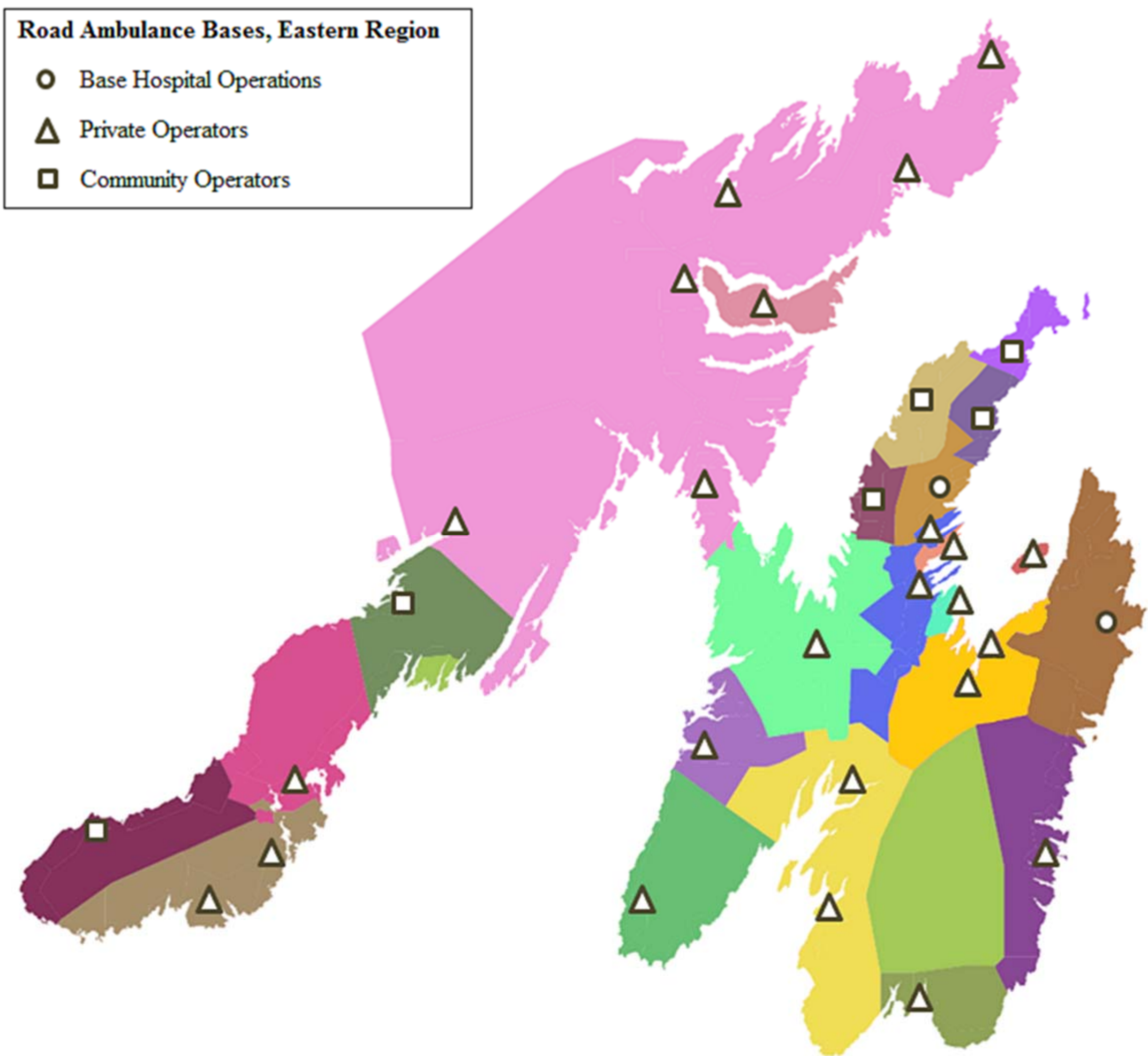
Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services and the Eastern Regional Health Authority (unaudited).

Private and community operators were established over time as the road ambulance program evolved. Private operators operate for profit. Community operators were often established when towns or community groups fundraised to purchase an ambulance to fill a need in their region.

Figure 1 shows the location of ambulance bases in the eastern region and the service areas designated to each operator.

**Figure 1**

**Department of Health and Community Services**
**Road Ambulance Program – Eastern Region**
**Ambulance Bases and Service Areas**
**March 31, 2015**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services and the NL 911 Bureau Inc. (unaudited).

# Detailed Observations

## 1. Road Ambulance Attendant Skill Level

**Objective**

To determine whether road ambulance services provided by base hospitals and private/community operators for Eastern Health have the appropriate skill levels required to provide quality care.

### Conclusion

Department of Health and Community Services policy requires a lower skill level for ambulance attendants than required by Canadian industry best practice.

Road ambulance services provided by the Eastern Regional Health Authority base hospitals have the appropriate skill levels required to provide quality care and is consistent with Canadian industry best practice.

Road ambulance services provided by private and community operators for the Eastern Regional Health Authority do not always have the skill levels required by Canadian industry best practice.

Road ambulance services provided by private operators for the Eastern Regional Health Authority do not always meet the skill levels required by the Department of Health and Community Services, which is lower than Canadian industry best practice.

**Overview**

The skill levels of ambulance attendants have a direct impact on the level of care and the treatment that is provided to patients.

In Canada and in Newfoundland and Labrador, it is standard to staff each ambulance transport with two attendants - one designated as the driver and the other designated as the primary care giver who travels in the back compartment with the patient throughout the transport.

Newfoundland and Labrador utilizes the paramedic competency sets outlined in the National Occupational Competency Profile (NOCP).

**Table 2**

**Department of Health and Community Services**
**Road Ambulance Program**
**Ambulance Attendant Training**
**March 31, 2015**

| NOCP Classification | Training Required | Training Available in Newfoundland and Labrador |
|---|---|---|
| Emergency Medical Responder (EMR) | 2 weeks | Yes |
| Primary Care Paramedic (PCP) | 40 - 68 weeks | Yes |
| Advanced Care Paramedic (ACP) | PCP plus 1 to 2 years | No |
| Critical Care Paramedic (CCP) | ACP plus additional training | No |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon information obtained from the Provincial Medical Oversight Program.

PMO is responsible for the registration of ambulance personnel.

**Table 3**

**Department of Health and Community Services**
**Road Ambulance Program**
**Ambulance Attendants by Classification**
**March 31, 2015**

| Classification | Number of Registered Attendants |
|---|---|
| Emergency Medical Responder (EMR) | 253 |
| Primary Care Paramedic (PCP) | 476 |
| Advanced Care Paramedic (ACP) | 40 |
| **Total** | **769** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Provincial Medical Oversight Program.

We assessed the road ambulance program against the following criteria:

A. The Department has established the minimum skill level required of attendants on every road ambulance transport in accordance with best practice.

B. Eastern Health ensures that road ambulance attendants meet the Department's standards for the continuing education and training requirements for all service personnel.

C. Eastern Health monitors whether all road ambulance transports include the required number of attendants at the required skill levels.

## 1A. Minimum Skill Level of Attendants

### Introduction

On each road ambulance transport, both attendants are responsible for providing and documenting patient care at the scene. It is important that both attendants have the appropriate skills to be able to perform their duties and provide quality care.

### Best Practice - Minimum Skill Level

Industry best practice in Canada is for all emergency ambulance transports to be staffed with two attendants at the level of PCP or above. No other province in Atlantic Canada allows EMRs to work on publicly funded ambulances. The only other provinces that register EMRs are British Columbia, Alberta, and Saskatchewan. In many cases, in these three provinces, the use of EMRs is limited to routine transports, or they work as first responders who provide basic life support until paramedics arrive.

### Policy - Minimum Skill Level

The current minimum skill level requirements in Newfoundland and Labrador for emergency transports in each service category are shown in Table 4.

**Table 4**

**Department of Health and Community Services**
**Road Ambulance Program**
**Skill Level Requirements**
**March 31, 2015**

| Service Category | Minimum Skill Level Required | |
|---|---|---|
| | Driver | Primary Care Giver |
| Hospital Services | EMR | PCP |
| Private Services | EMR | PCP |
| Community Services | EMR | EMR for 75% of the calls and a PCP for the remaining 25% for each base |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon information obtained from the Provincial Medical Oversight Program.

The skill level requirements included in the Standards Manual were last updated in March 2006 for hospital services and March 2007 for private and community services and did not reflect the current registration classifications.

Department policy requires ambulance drivers in all service categories to have a minimum classification of EMR. This is a lower level of skills than Canadian industry best practice requires. Department policy also allows the primary care giver on a community ambulance to be an EMR in some cases, which is a lower standard than Canadian industry best practice.

## Findings

1. The policy of the Department of Health and Community Services outlining the minimum skill level required for drivers and primary care givers on emergency road ambulance transports is outdated and does not reflect the current requirements of the road ambulance program.

2. The minimum skill level for ambulance attendants required by the Department of Health and Community Services on emergency road ambulance transports is less than Canadian industry best practice.

## 1B. Training and Continuing Education

### Introduction

All ambulance attendants must be registered and certified by the PMO in order to work on an ambulance in this province. The registration and certification process ensures that each registrant has completed the required training and continuing education for their registration level.

Eastern Health is responsible for ensuring that road ambulance attendants used in both its hospital ambulance services and by private and community operator services in their region meet the Department's standards for training and continuing education.

### Ambulance Attendants

All attendants are required to be registered and to re-register annually. The annual requirements include proof of continuing medical education, clinical exposure and maintenance of competency logs.

Once registered, attendants must pass the applicable protocol exam for their classification in order to obtain certification.

The annual registration process is to be completed each year by March 31. PMO provides a report of all registered attendants to operators and the Department. This report is updated throughout the year as needed. During our audit, we selected a random sample of registered attendants and reviewed documentation to ensure each had met the registration and certification requirements of PMO. All the attendants in our sample met the registration and certification requirements of the PMO.

## Finding

3. The Provincial Medical Oversight Program ensured that the registered ambulance attendants in the sample we examined had the required education and training consistent with their classification.

**Dispatchers**

In an emergency situation the dispatcher is the first point of contact with the scene. The Department strongly recommends that all ambulance services utilize appropriately trained and registered dispatchers. However, since this is not a requirement, PMO does not require that all dispatchers register through them. PMO does maintain the registration of those that choose to complete the designated training program.

Eastern Health requires dispatchers employed with their service to be registered. However, not all private and community operators throughout the region have trained dispatchers on staff.

Different training levels have the potential to lead to inconsistencies in the approach to dispatch throughout the region. Without a standardized approach to dispatch training, the call taker could focus solely on obtaining the location of the scene and fail to obtain other information that could assist with the critical situation. This could create a delay in bringing patient care to the scene until the time an ambulance arrives. In rural areas of the region, where response times could be longer, a standardized approach to dispatch could result in improved patient care.

**Findings**

4. The Department of Health and Community Services does not require dispatchers to have a minimum level of training or to be registered through the Provincial Medical Oversight Program.

5. The Eastern Regional Health Authority requires the dispatchers it employs for its base hospital ambulance operations to be appropriately trained.

## 1C. Monitoring of Attendant Skill Level on Ambulance Transports

**Introduction**

Eastern Health is responsible for monitoring ambulance transports in the eastern region of the Province to ensure that they contain two attendants at the appropriate skill level and that they have maintained their registration and certification with PMO.

**Monitoring - Hospital Services**

The minimum Department policy requires the driver of an ambulance to be an EMR for hospital based services. However, Eastern Health only employs attendants at the level of PCP or above. Eastern Health practice therefore ensures that every road ambulance transport within its operations exceeds the minimum staffing requirements of the Department and meets the industry best practice in Canada.

Eastern Health should have processes in place to ensure that each hospital ambulance transport has two attendants that are appropriately registered and certified. We reviewed dispatch data for hospital ambulance transports for the period of April 1, 2013 to September 30, 2015 that included information such as attendants' names, patient details, time the call was received and dispatched and when attendants arrived on scene.

Eastern Health has processes in place to ensure that each hospital ambulance transport has two attendants that are appropriately registered and certified.

## Finding

6. The Eastern Regional Health Authority employs hospital ambulance attendants at a skill level that is consistent with Canadian industry best practice. This is a higher skill level than required by the Department of Health and Community Services.

**Monitoring - Private and Community Services**

Eastern Health maintains a database of private and community ambulance transports. Transport data is keyed into the database by employees in the Corporate Finance division of Eastern Health from copies of the Patient Care Report (PCR) that are submitted to them as a claim for payment. A PCR is required to be completed for every publicly funded road ambulance transport in the Province. This form is used for service invoicing by the private and community operators and documenting the medical record of the patient.

This system has an adjudication process to ensure that there is a valid ambulance attendant registration number on a PCR. If an attendant is not currently registered, the system will deny the claim.

We obtained the transport data for the scope period of our audit. We compared the attendant registration numbers used in transports in the database to PMO's registration information. We found that in all instances the attendant had a valid registration number.

*Private Ambulance Operators*

Canadian industry best practice requires that ambulance drivers have a minimum classification of PCP.

Department policy requires drivers to have a minimum classification of EMR which is a lower level of skills than Canadian industry best practice requires. Private operators are meeting the Department's minimum driver skill level policy requirement, however, this is less than Canadian industry best practice.

Canadian industry best practice also requires that primary care givers have a minimum classification of PCP. This is consistent with Department policy.

From April 1, 2014 to September 30, 2015, 18 of the 24 private operator bases did not have at least one PCP on each emergency transport.  This is contrary to Department policy.

Table 5 shows the number of emergency transports from privately operated bases in the eastern region with no PCP on board. This information was compiled based on data reported by the private ambulance operators. We have not verified the accuracy of this information.

**Table 5**

**Department of Health and Community Services**
**Road Ambulance Program – Eastern Region**
**Privately Operated Ambulances – Emergency Transports with No PCP**
**For the year ended March 31, 2015**

| Private Operator Base | Number of Emergency Transports | Number of Emergency Transports with No PCP | Percentage of Emergency Transports with no PCP |
|---|---|---|---|
| Terrenceville | 86 | 85 | 99% |
| Upper Island Cove | 274 | 156 | 57% |
| Arnold's Cove | 216 | 86 | 40% |
| St. Lawrence | 160 | 55 | 34% |
| Bonavista/Catalina | 803 | 275 | 34% |
| Port Rexton | 157 | 49 | 31% |
| Trepassey | 175 | 41 | 23% |
| Random Island | 128 | 26 | 20% |
| Ferryland | 334 | 21 | 6% |
| Bell Island | 415 | 23 | 6% |
| St. Bride's | 154 | 8 | 5% |
| Burin | 194 | 8 | 4% |
| Lethbridge | 279 | 10 | 4% |
| Brigus | 274 | 9 | 3% |
| Clarenville | 1,340 | 8 | 1% |
| Clarke's Beach | 1,301 | 6 | 1% |
| Marystown | 632 | 2 | 1% |
| Harbour Grace | 445 | 1 | 1% |
| Mount Carmel | 180 | - | - |
| St. Mary's | 263 | - | - |
| Placentia | 398 | - | - |
| Holyrood | 510 | - | - |
| Kelligrews | 1,948 | - | - |
| Whitbourne | 687 | - | - |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services (unaudited).

*Community Ambulance Operators*

Canadian industry best practice requires that ambulance drivers have a minimum classification of PCP.

Department policy requires drivers to have a minimum classification of EMR which is a lower level of skills than Canadian industry best practice would require. Community operators are meeting the Department's minimum policy requirement, however, this is less than Canadian industry best practice.

Canadian industry best practice requires that the primary care giver have a minimum classification of PCP.

Department policy allows community operators to have an EMR as the primary care giver for up to 75% of the calls, but must have a PCP on the remaining 25% for each base. This is a lower level of skill than Canadian industry best practice requires.

The Department holds community operators to a lesser standard than private operators. It requires a PCP or above on only 25% of ambulance transports. There is no difference between patients served by community operators and private operators. While all community operator bases were in compliance with Department policy, this was a lower standard than Canadian industry best practice and is a lower requirement than private operators.

Table 6 shows the number of emergency transports from community operated bases in the eastern region with no PCP on board. This information was compiled based on data reported by the community ambulance operators. We have not verified the accuracy of this information.

**Table 6**

**Department of Health and Community Services**
**Road Ambulance Program - Eastern Region**
**Community Operated Ambulances - Emergency Transports with No PCP**
**For the year ended March 31, 2015**

| Community Operator Base | Number of Emergency Transports | Number of Emergency Transports with No PCP | Percentage of Emergency Transports with No PCP |
|---|---|---|---|
| Winterton | 110 | 72 | 65% |
| Old Perlican | 337 | 209 | 62% |
| Hearts Delight | 259 | 64 | 25% |
| Adams Cove | 108 | 14 | 13% |
| Bay L'Argent | 183 | 9 | 5% |
| Grand Bank | 496 | 1 | - |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services (unaudited).

Of the six community operated bases in the Eastern region, all transports were consistent with the Department's policy, but less than Canadian industry best practice.

## Findings

7. The Eastern Regional Health Authority has processes in place to ensure that ambulance attendants reported on an ambulance transport are registered by the Provincial Medical Oversight Program.

8. Privately operated ambulance bases in the eastern region did not always have at least one Primary Care Paramedic on emergency transports. The policy of the Department of Health and Community Services requires the use of at least one Primary Care Paramedic on all emergency transports conducted by private operators.

9. The Department of Health and Community Services holds community operators to a lesser standard than private operators. It requires a Primary Care Paramedic or above on only 25% of ambulance transports. There is no difference between patients served by community operators and private operators. While all community operator bases in the eastern region were in compliance with Department of Health and Community Services policy, this was a lower standard than Canadian industry best practice and is a lower requirement than private operators.

**"Best Efforts"**

The Standards Manual requires that if an operator is unable to meet the Department's standard for skill level they are required to apply for a temporary exemption under the "Best Efforts" policy. According to this policy, an exemption shall only apply if the operator has made several attempts to hire appropriately trained personnel and/or has made several attempts to upgrade the training of current employees. An operator must submit a formal request with supporting evidence of the steps they have followed in an effort to recruit or upgrade staff.

A large number of private operators were using two attendants at the EMR level on emergency ambulance transports. However, neither the Department nor Eastern Health had documentation for any requests for relief under the "Best Efforts" policy during the scope of our audit. We cannot determine whether operators were attempting all reasonable steps to ensure that they have the appropriately trained personnel.

## Finding

10. The Ambulance Operations Standards Manual requires ambulance operators to make "best efforts" to ensure ambulance attendants have the required skills to work on an ambulance. Operators must submit a formal request to the Department of Health and Community Services for an exemption from the skills policy with evidence of the steps they have followed in an effort to recruit or upgrade staff. Despite the fact that private ambulance operators employ attendants with less than the required skill levels, neither the Department of Health and Community Services nor the Eastern Regional Health Authority had documentation for any requests for relief under the "Best Efforts" policy.

## 2. Road Ambulance Response Times

**Objective**

To determine whether road ambulance response times at Eastern Health are meeting the needs of residents of the eastern region of the Province.

### Conclusion

The Eastern Regional Health Authority's hospital based ambulance service is not always meeting its response time benchmark for the metro St. John's region and, therefore, may not be meeting the needs of residents of the metro St. John's region.

The hospital ambulance operation in Carbonear is meeting the Canadian industry best practice response time benchmark for rural areas.

Not all private and community ambulance operators meet the Canadian industry best practice response time benchmark for rural areas and, therefore, may not be meeting the needs of rural residents of the eastern region.

**Overview**

Ambulance response time is defined as the time it takes an ambulance to arrive on scene from the time the call is received by a dispatcher. Ambulance response times are a critical component of health care as the primary mandate of the road ambulance service is to respond to patients in emergency situations.

We assessed the road ambulance program against the following criteria:

A. The Department has response time benchmarks that road ambulance service providers are required to meet and these benchmarks are communicated to all ambulance operators.

B. Eastern Health monitors and assesses response times to ensure that they are consistent with established benchmark expectations.

### 2A. Response Time Benchmarks

**Introduction**

A benchmark is a standard, or point of reference, against which results may be compared or assessed.

**Response Time**

Best practice within urban areas of Canada is for an ambulance to arrive on scene within nine minutes of the call for service.

There is a greater amount of variation in response time benchmarks for areas classified as rural or remote across the country. Benchmarks for rural areas were found to be anywhere from 15 to 40 minutes. A report from Fitch and Associates, commissioned by the Department on the Provincial ambulance program in 2013, indicates an industry standard benchmark of 14:59 minutes for rural areas and 29:59 minutes for remote areas. This is consistent with the benchmarks reported being used by Nova Scotia in a 2010 Auditor General report, of less than 15 minutes for an urgent call in an area with a population of 2,500 to 14,999, and less than 30 minutes for areas with a population under 2,500. In 2015, Alberta introduced targets of 12 minutes for urban areas, 15 minutes for communities with populations greater than 3,000, and 40 minutes for rural areas.

Eastern Health has established its own benchmark to achieve a ten minute response time, 90% of the time, within the metro St. John's region with its hospital emergency ambulance transports.

The Department and Eastern Health have not set any targets for ambulance services outside the metro St. John's region related to response times. They have set a target for chute time of ten minutes, which is the time it takes from the point when an ambulance is dispatched to an emergency call until the ambulance begins continuous travel enroute to the call location. There is no measurable standard for private and community operators and the hospital ambulances services in Carbonear to arrive at the call location.

## Findings

11. The Eastern Regional Health Authority has established a ten minute ambulance response time benchmark for its own ambulance operations in the metro St. John's area. However, it has not established a response time benchmark for its Carbonear operations.

12. The Department of Health and Community Services and the Eastern Regional Health Authority have not set any ambulance response time targets for ambulance services outside the metro St. John's region.

## 2B. Monitoring and Assessment of Response Time Benchmarks

**Introduction**

Eastern Health is responsible for monitoring road ambulance services to ensure that the operations in the Eastern region are meeting the standards set by the Department.

**Monitoring - Hospital Services**

***Metro St. John's Region***

Eastern Health's ten minute response time, 90% of the time, benchmark in the metro St. John's region is a higher standard than the ten minute chute time benchmark established by the Department.

The response time benchmark was used by Eastern Health for planning purposes, such as determining the location of bases and the number of ambulances required. However, we did not find evidence of monitoring or periodic reporting of actual response time performance against the benchmark.

We reviewed data from the Eastern Health dispatch system to determine whether Eastern Health is meeting its benchmark for response time.

- For the period of April 1, 2014 to March 31, 2015, Eastern Health was only meeting the ten minute response time benchmark 83% of the time.

- There is no standardized clock used for time entry which creates imprecision in the times recorded in the system. A difference of even a couple of minutes could have a significant impact on the assessment against a response time benchmark of ten minutes.

The calculation of response time is a function of the manual recording of the time the call comes in and the time the attendants reach the location. Because this is not an automated process, there is a risk there is imprecision in the response time data.

***Carbonear***

Eastern Health has not established a response time benchmark for its own ambulance operations in Carbonear and we did not find evidence of monitoring or periodic reporting of actual response times for this base.

We reviewed data available to assess whether the hospital ambulance operation in Carbonear was meeting the Department's chute time benchmark of ten minutes, 90% of the time. For the period of April 1, 2014 to March 31, 2015, the Carbonear operation was meeting the benchmark.

We also analyzed the data based on benchmarks for rural areas used in other parts of the country and found that the hospital ambulance operation in Carbonear was meeting the Canadian industry response time benchmark for rural areas of 15 minutes, 90% of the time.

## Findings

13. The Eastern Health Regional Health Authority was not monitoring the hospital based ambulance service to ensure road ambulance transports were meeting the response time benchmark.

14. The hospital ambulance operations in the metro St. John's region are not always meeting the ten minute response time benchmark established by the Eastern Regional Health Authority.

15. The Eastern Regional Health Authority has not established a response time benchmark for its own ambulance operations in Carbonear. The hospital ambulance operation in Carbonear is meeting the Department of Health and Community Services chute time benchmark of 10 minutes, 90% of the time. It was also meeting the Canadian industry response time benchmark for rural areas of 15 minutes, 90% of the time.

**Monitoring - Private and Community Services**

Eastern Health is responsible for overseeing the contracts between the Department, Eastern Health and the private and community operators for the eastern region of the Province. This would include monitoring the chute time and overall response times of private and community ambulance operators. The contracts between the Department, Eastern Health and the private and community operators do not contain any benchmarks for overall response time.

Eastern Health does not monitor the chute time or overall response times of private and community operators.

We reviewed data related to response times to assess whether or not the private and community operators are meeting the benchmarks for chute time. We also reviewed the data to determine overall response times. There is no centralized dispatch for private and community ambulances and no automated system to record response data. This lack of automation could impact the precision of the data.

For the period of April 1, 2014 to March 31, 2015, one of the six community operators and seven of the 24 private operator bases did not report meeting the Department benchmark of ten minute chute time, 90% of the time.

Using the system data, we calculated response times for private and community operators and analyzed them based on benchmarks for non-urban areas used in other parts of the country. We found that:

- 1 of 6 community operators did not report responding to emergency calls within 30 minutes, more than 90% of the time; and
- 10 of 24 private operator bases did not report responding to emergency calls within 30 minutes, more than 90% of the time.

In order to assess the reliability of the reported data on response times by private and community operators, we attempted to match PCRs prepared by ambulance attendants with the data contained in the Eastern Health system.

We requested a sample of 100 hospital copies of PCRs in order to trace times entered to the final copies submitted by operators for payment. PCRs are required to be filled out before the attendants leave the patient, with a copy left at the facility to become part of the patient's medical records. If this form is completed prior to the attendants leaving the facility, the copy remaining there should be the same as the copy submitted to Corporate Finance by the operator for payment.

Of the 100 PCRs requested from Eastern Health, only 18 copies could be provided. We were unable to determine whether road ambulance attendants did not leave the 82 records at the medical facility or if they were misplaced by Eastern Health. The PCR forms part of the patient record.

Ambulance attendants are required to record the time at five points in the process on the PCR prior to leaving the patient. Of the 18 records received, six were missing at least one of the five required times. We found one case where none of the required time fields were recorded on the PCR. We compared the PCR copy left by the ambulance attendant in the patient's file with the copy sent by the operator to Corporate Finance. In all 18 cases the data obtained from Corporate Finance included all five times. This indicates that in at least six cases, PCRs were altered after the transport was complete.

## Findings

16. The Eastern Regional Health Authority is not monitoring private and community operators to ensure road ambulance transports are meeting the chute time benchmark.

17. Patient Care Reports, which are prepared by ambulance attendants and are required to be included in the patient medical record, were missing in 82 of 100 patient files we examined.

18. Six of the Patient Care Reports that were available for examination had been altered after the patient transport was completed.

## 3. Governance and Oversight Provided by the Department

**Objective**

To determine whether the Department exercises effective oversight of the RHAs' responsibilities in operating the road ambulance program.

### Conclusion

The Department of Health and Community Services is not providing effective oversight of the road ambulance program.

**Overview**

The Department is responsible for developing and implementing policies and procedures related to the road ambulance program. Its role is to provide oversight and to monitor the delivery of ambulance services by RHAs. This is intended to ensure that the Province benefits from best practices, standards and guidelines prevalent in other jurisdictions.

We assessed the road ambulance program against the following criteria:

A. The Department has clearly defined its performance objectives, targets and information needs to the RHAs for road ambulance services.

B. The Department has clearly communicated its expectations of the RHAs' and PMO's performance and reporting requirements.

C. The Department conducts regular monitoring and evaluation of required information received from the RHAs and PMO to ensure the program is meeting its objectives.

### 3A. Performance Objectives, Targets and Information Needs

**Introduction**

Regular monitoring and evaluation of legislation, programs, plans and funding outcomes are important to maintain the effectiveness of the health and community services system. Evaluation of the road ambulance program requires appropriate benchmarks or targets to effectively measure performance. Entities use performance objectives to measure success and progress. An important principle in establishing performance objectives is that they be specific, measurable and achievable, with specific time lines.

**Performance Objectives and Targets**

The Department is responsible for oversight of the RHAs. Performance objectives and targets would allow the Department to evaluate the operations of the road ambulance program in each of the regions.

Contracts between the Department, Eastern Health and private and community operators require that the Department "develop performance evaluation criteria through which the performance of the Service Provider will be evaluated, based on nationally accepted standards, in the areas of patient care, documentation, service delivery, and adherence to policy, procedures and standards".

The Department has developed the Standards Manual and policies and procedures to govern the daily operations of road ambulance service providers. These documents describe to operators and attendants how patient care is to be provided, and how it is to be documented.

While the Department has developed policies and procedures, the only performance objective or target which is communicated to road ambulance operators is chute time.

## Finding

19. The Department of Health and Community Services has not established performance objectives or evaluation criteria for the road ambulance program, with the exception of chute time. This limits the ability of the Department of Health and Community Services to effectively monitor performance.

**Information Needs**

The RHAs are responsible for the day-to-day operations of the road ambulance program. Regular reporting on the operations of the road ambulance program from the RHAs, such as compliance with attendant skill level policy and any violations of base service areas coverage requirements, would allow the Department to monitor and evaluate the effectiveness of the program. We found no documented reporting requirements.

## Finding

20. The Department of Health and Community Services has not established any reporting requirements for the Regional Health Authorities with regards to the operation of the road ambulance program.

## 3B. Communication of Expectations

### Introduction

To ensure the road ambulance program is operated in an efficient and effective manner, the Department should clearly communicate its expectations to the RHAs and the PMO.

### Communication between the Department, Eastern Health and PMO

The Department has not clearly defined any performance objectives, targets or information needs, and therefore there was no communication of such to the RHAs or PMO.

Communications were generally related to daily operational issues, such as enforcement of policies or registration of attendants.

### Finding

21. The Department of Health and Community Services has not communicated clearly defined performance objectives, targets or information needs to the Regional Health Authorities or the Provincial Medical Oversight Program for the road ambulance program.

### Policies and Procedures

The Department has developed policies and procedures for the operation of the road ambulance program and has also established the Standards Manual.

In a number of instances, the Standards Manual has not been updated to reflect current practices. These were cases where an error existed in the text of the Standards Manual or a change has been made affecting the program, but the Standards Manual has not been corrected or amended to reflect this change.

Some examples are:

- the responsibility of day-to-day operations has been delegated to the RHAs and PMO, yet the Standards Manual still only refers to the responsibility of the Department;
- submissions for suggested changes are directed to be sent to the Director of Board Services which is a position that no longer exists;
- attendant classifications such as EMR Trainee and EMR II are used in the Standards Manual but are no longer recognized in the Province;
- a paragraph is preceded by "[delete]" which appears to suggest that it should have been removed from the Standards Manual; and
- appendix H is blank but is intended to contain information on Standard Ambulance Designs.

There were also a number of instances where policies referenced in the Standards Manual were not available on the website. These policies were no longer in effect, but the references had not been removed from the Standards Manual.

Some sections of the Standards Manual and related policies were still in effect, but are not being enforced by the Department. For example, the Multiple/Mass Casualty Incident Plans/Submission Requirements policy states that the Department will provide operators with a blueprint of this plan, and the private operators are to use this to outline their own response when dealing with a mass casualty incident and submit this to the Department. Neither the Department nor Eastern Health had any record of such plans, or the blueprint that they would provide to operators if requested.

## Findings

22. The Department of Health and Community Services is not updating the policies and procedures and Ambulance Operations Standards Manual to reflect current practices.

23. In some instances, the policies governing the daily operations of the road ambulance program were not being enforced.

## 3C. Monitoring and Evaluation

### Introduction

The Department is responsible to conduct regular monitoring and evaluation of the functions of the RHAs and PMO to ensure they are meeting their objectives.

### Monitoring and Evaluation

The Department has not set any benchmarks or performance objectives for the road ambulance program, and it is not receiving regular reports about the operation. The Department has not conducted any monitoring of the road ambulance program. It did not collect, monitor, or publicly report information on service timeliness, service reliability or client outcomes.

The Department hired a consultant to review the road ambulance program and provide analysis and recommendations for program improvements. The consultant's final report was issued in August 2013. The consultant recommended that six of the recommendations be completed within the first 24 months. At the end of our scope period neither of these recommendations had been implemented.

## Findings

24. The Department of Health and Community Services does not monitor the road ambulance program to determine whether the intended results were achieved.

25. While the Department of Health and Community Services hired a consultant to review the road ambulance program, two years after the report was issued, none of the immediate term recommendations have been completed.

## 4. Governance and Oversight Provided by Eastern Health

**Objective**

To determine whether Eastern Health has processes in place to effectively monitor the day-to-day operations of road ambulance services provided by base hospitals and private/community operators, and their compliance with Department policy.

### Conclusion

The Eastern Regional Health Authority has some processes in place to monitor the day-to-day operations of the road ambulance services within its region; however, these processes are not effective in determining whether road ambulance services provided in the region are in compliance with Department of Health and Community Services policy.

**Overview**

The RHAs are responsible for the day-to-day operations of the road ambulance program in their region.

We assessed the road ambulance program against the following criteria:

A. Performance expectations of Eastern Health for road ambulance services are communicated to hospital and private/community operators.

B. Systems and practices are in place at Eastern Health to monitor performance of road ambulance services provided by base hospitals and private/community operators, and their compliance with Department policy.

### 4A. Communication of Performance Expectations

**Introduction**

To provide effective oversight of the road ambulance program, performance expectations must be set and communicated to the private and community ambulance operators. This ensures that operators are aware of their responsibilities and that they know what information must be communicated to Eastern Health.

**Communication to Ambulance Operators**

The Standards Manual, policies and procedures, and contracts are used to convey performance expectations to ambulance operators. However, the Standards Manual has not been updated since 2006 and is not fully reflective of the current requirements. For example, the Standards Manual has not been updated since the formation of PMO which is now responsible for performance monitoring in the areas of attendant registration and quality assurance.

The Standards Manual and policies and procedures are available to ambulance operators through the Eastern Health website. However, the website is not organized in a user friendly manner making it difficult to locate policies referenced in the Standards Manual. Policies on the website are listed by title, yet in the Standards Manual they are referenced by policy number.

Despite the fact that policies and procedures are outdated, the RHAs have to rely on the Department to update and communicate these policies and procedures to ambulance operators. RHAs are responsible for the day-to-day operations of the road ambulance program in their region; however, they have no ability to change policies and procedures.

## Findings

26. The Ambulance Operations Standards Manual and related policies and procedures are not conveyed to operators in an easy to follow format.

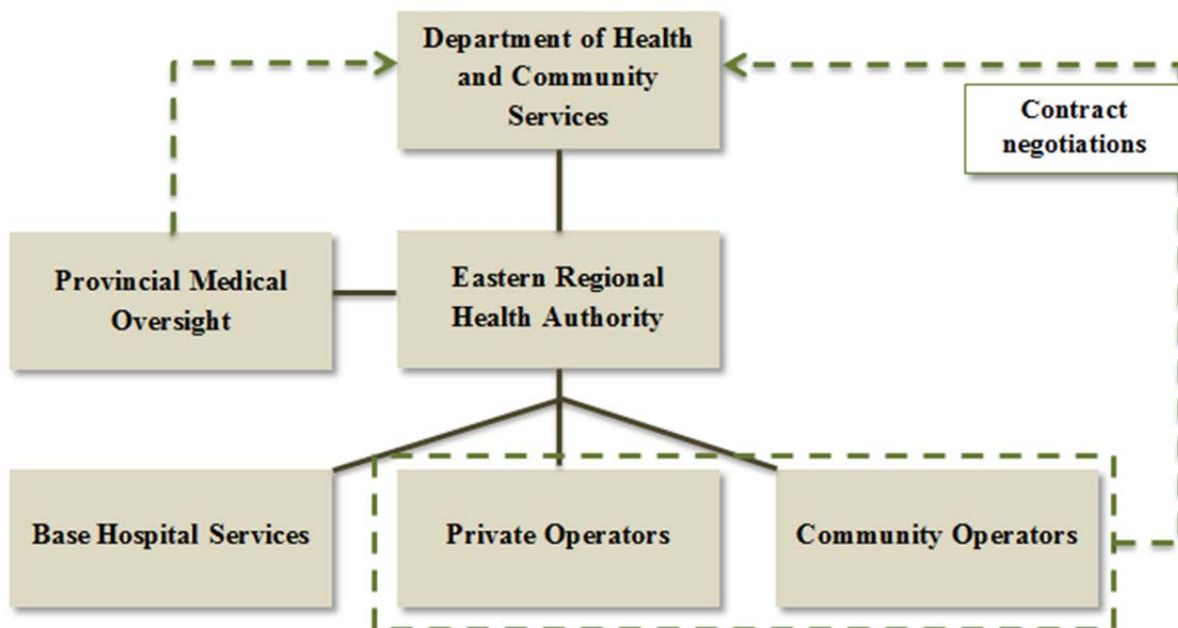
27. Despite the fact that policies and procedures are outdated the Regional Health Authorities have to rely on the Department of Health and Community Services to update and communicate these policies and procedures to ambulance operators. Regional Health Authorities are responsible for the day-to-day operations of the road ambulance program in their region; however, they have no ability to change policies and procedures.

**Contracts**

Figure 2 illustrates the relationship between the parties involved in the road ambulance program.

**Figure 2**

**Department of Health and Community Services**
**Road Ambulance Program – Eastern Region**
**Organizational Chart**
**March 31, 2015**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services and the Eastern Regional Health Authority.

The contracts between the Department, Eastern Health and the private or community operators are the primary method used to establish expectations for the road ambulance program. Contracts are negotiated between the Department and the operators, or the association to which they belong. Contracts were in effect from 2008 to 2012. While the contracts provided for an automatic extension, new contracts were not signed until mid to late 2015, resulting in a period in excess of three years without a new contract in place.

The Department has provided RHAs with the responsibility for operating the road ambulance program. The Department engages in lengthy contract negotiations with the associations representing private and community ambulance operators but do not involve the RHAs in the negotiation process. Officials working within the RHAs have knowledge and experience specific to paramedicine to be able to research and design an effective program. The Department may be limiting its ability to ensure contracts effectively serve the people of the Province, if it does not involve the RHAs in contract negotiations.

## Findings

28. Contract negotiations extended three years beyond the original expiry date of previous contracts between the Department of Health and Community Services, the Eastern Regional Health Authority and the private and community operators.

29. The Department of Health and Community Services does not seek the advice of the Regional Health Authorities when negotiating contracts with private and community ambulance operators despite the operational expertise that exists at the Regional Health Authorities.

## 4B. Performance Monitoring

### Introduction

Eastern Health should have systems and processes in place to monitor performance and compliance with Department policy of road ambulance services provided by base hospitals, and private and community operators.

### Monitoring and Reporting

*Private and Community Based Operators*

Eastern Health is not monitoring response times of ambulance transports by private and community operators, however, it relies on the adjudication process performed by the Corporate Finance division, and the quality assurance investigations performed by PMO to monitor adherence to other Department policies.

The adjudication process uses data keyed from the PCRs and verifies that the information reported is consistent with relevant policies. For example, it assesses whether the attendant and driver on each transport are registered with PMO, and whether all time stamps have been entered.

In our testing of PCRs we determined that reports had been altered after the patient transports were completed, which resulted in copies of PCRs in patient’s files that were different than the copies of the PCRs that were adjudicated by Corporate Finance.

Quality assurance performed by PMO also relies on information submitted from ambulance operators and complaints being received from the public. Processes performed by PMO rely on information that is reported manually and there is no process in place to ensure that information received is complete.

*Hospital Based Ambulance Operations*

Eastern Health is not monitoring response times of ambulance transports by its hospital based ambulance operations, however, it relies on the adjudication process performed by the Corporate Finance division, and the quality assurance investigations performed by PMO to monitor adherence to other Department policies. Eastern Health has also established its own policies that govern the systems and practices in place.

Eastern Health monitors its hospital based ambulance service based on call volume, instances of red alerts and unit hour utilization (UhU). Statistics are used for annual scheduling and planning purposes.

A red alert happens when all ambulances are currently in use and there is no remaining ambulance to respond to an emergency call. In this situation the operator will have to rely on another ambulance operator to respond.

UhU is a calculation based on the number of available ambulances and the number of calls and is used to measure the utilization of the system. Eastern Health monitors UhU by shift to allow them to allocate resources in a way that reduces the strain on the system.

**Finding**

30. While the Eastern Regional Health Authority has some systems and processes in place to monitor the operations of road ambulance services provided by base hospitals, and private and community operators, these systems and processes do not monitor all aspects of the operations of the road ambulance program.

# Recommendations

1. The Department of Health and Community Services should evaluate its basis for road ambulance attendant skill level policy, which is below Canadian industry best practice, and determine whether it is sufficient to ensure quality care.

2. The Eastern Regional Health Authority should ensure that the road ambulance services provided by private and community based operators for the Eastern Regional Health Authority meet the skill levels required by the Department of Health and Community Services. In instances in which operators demonstrate that they must temporarily employ attendants with less than the required skill levels, the Eastern Regional Health Authority and the Department of Health and Community Services should ensure there is adequate documentation for relief under the "Best Efforts" policy.

3. The Department of Health and Community Services should ensure that its policies and procedures and the Ambulance Operations Standards Manual:

    - are up to date and reflect all requirements of the road ambulance program;
    - are being enforced; and
    - are conveyed to operators in an easy to follow format.

4. The Department of Health and Community Services should evaluate its basis for dispatcher training, and determine whether it is sufficient to ensure quality care.

5. The Department of Health and Community Services should set ambulance response time targets, giving consideration to Canadian industry best practice for response times.

6. The Eastern Regional Health Authority should ensure targets that the Department of Health and Community Services sets are being monitored for the eastern region of the Province.

7. The Eastern Regional Health Authority should ensure that Patient Care Reports are included in patient medical records and that the Patient Care Reports are not altered after the patient transports are completed.

8. The Department of Health and Community Services should ensure it is providing effective oversight of the road ambulance program, through the establishment and communication of clearly defined performance objectives and its information needs to the Regional Health Authorities and the Provincial Medical Oversight Program.

9. The Department of Health and Community Services should ensure that contracts with the private and community operators are negotiated and renewed in a timely manner and ensure that it seeks the advice of the Regional Health Authorities when negotiating the contracts.

10. The Department of Health and Community Services should monitor the road ambulance program to ensure intended results are achieved.

11. The Eastern Regional Health Authority should have systems and processes in place to effectively monitor the day-to-day operations of road ambulance services provided by base hospitals and private and community operators, and their compliance with Department of Health and Community Services policy.

# Department of Health and Community Services Response

1. *The Department of Health and Community Services should evaluate its basis for road ambulance attendant skill level policy, which is below Canadian industry best practice, and determine whether it is sufficient to ensure quality care.*

   ***Department's Response:***
   *The Department's ambulance attendant skill level policy is in keeping with the current supply of ambulance attendants that has a larger pool of the less qualified Emergency Medical Responders available to hire rather than the higher skilled Primary Care Paramedics (PCP). The Department is aware that the current ambulance attendant skill mix is not optimal. To address this concern the Department is working with public and private PCP training institutions on initiatives to increase PCP training capacity. As more PCPs become available for hire the Department will review and update its skill level policy.*

2. *The Eastern Regional Health Authority should ensure that the road ambulance services provided by private and community based operators for the Eastern Regional Health Authority meet the skill levels required by the Department of Health and Community Services. In instances which operators demonstrate that they must temporarily employ attendants with less than the required skill levels, the Eastern Regional Health Authority and the Department of Health and Community Services should ensure there is adequate documentation for relief under the "Best Efforts" policy.*

   ***Department's Response:***
   *The Department recognizes that private and community ambulance operators are having challenges recruiting sufficient PCPs to meet current provincial ambulance staffing standards. The Department is working with the province's public and private training institutions to increase PCP training capacity in an effort to increase the supply of PCP's to meet the ambulance program's staffing standards. In the interim, the Department will work with the Regional Health Authorities and the ambulance industry on a process to document the circumstances when operators seek relief under the "Best Effort" policy.*

3. *The Department of Health and Community Services should ensure that its policies and procedures and the Ambulance Operation Standards Manual:*
   - *are up to date and reflect all requirements of the road ambulance program;*
   - *are being enforced; and*
   - *are conveyed to operators in an easy to follow format.*

   ***Department's Response:***
   *The Department has rewritten and reformatted all road ambulance policies into a consistent language. HCS is nearing completion of dedicated bi-weekly teleconferences with the Regional Health Authorities (RHAs) to review the revised policies and procedures. Once the RHAs review is complete the revised policies will be shared with ambulance operators as a final check prior to implementation. Once implemented, the revised policies will guide provincial road ambulance operations. Work will then begin on updating the Ambulance Standards Manual. The Department works with the RHAs to enforce existing policies. The*

*Department also recognizes the need to improve the presentation format of its manuals and is making these changes during the revision process.*

4. *The Department of Health and Community Services should evaluate its basis for dispatcher training, and determine whether it is sufficient to ensure quality care.*

   ***Department's Response:***
   *The Department will evaluate the basis for dispatcher training to determine if it is sufficient to ensure quality care as it moves forward to implement a Central Medical Dispatch Center as recommended by Fitch and Associates in the Provincial Road Ambulance Review.*

5. *The Department of Health and Community Services should set ambulance response time targets, giving consideration to Canadian industry best practice for response times.*

   ***Department's Response:***
   *The Department recognizes the need to establish ambulance response time targets and is working towards Government approval for the acquisition of the electronic data gathering technology required to establish, monitor and enforce realistic and specific response time targets. As a first step towards electronic data gathering HCS is finalizing the installation of Automatic Vehicle Location systems on all publically funded ambulances in the province which now allows HCS to track ambulance operations.*

8. The Department of Health and Community Services should ensure it is providing effective oversight of the road ambulance program, through the establishment and communication of clearly defined performance objectives and its information needs to the Regional Health Authorities and the Provincial Medical Oversight Program.

   ***Department's Response:***
   *The Department recognizes the important role effective communication plays in the oversight of the road ambulance program. The Department has established bi-monthly conference calls and an annual face to face meeting with RHA paramedicine management to discuss issues within the program and to identify areas for improvement. As electronic data gathering is implemented HCS will work with the RHAs to establish clearly defined and communicated performance targets and reporting requirements. The Department also agrees to undertake initiatives to more clearly define the Department's performance objectives and information needs to the Provincial Medical Oversight Program.*

9. *The Department of Health and Community Services should ensure that contracts with the private and community operators are negotiated and renewed in a timely manner and ensure that it seeks the advice of the Regional Health Authorities when negotiating the contracts.*

   ***Department's Response:***
   *The Department agrees to discuss the Auditor General's concerns with the Human Resource Secretariat, who is responsible for scheduling and leading the ambulance operator Service Agreement negotiations, to determine if negotiations can start as outlined in the 2014-2017 Service Agreements. However it needs to be recognized that Government is only one party in*

*the negotiation's process and does not have full control over the negotiation's timelines. The Department will seek advice from the RHA's to inform future ambulance operator negotiations.*

10. *The Department of Health and Community Services should monitor the road ambulance program to ensure intended results are achieved.*

    ***Department's Response:***
    *The Department recognized in 2012 that the Provincial Road Ambulance Program's operations and monitoring needed modernizing. To address the Department's concerns Fitch and Associates was hired to complete a road ambulance review which was delivered in October 2013. Based on Fitch's ten recommendations the Department has initiated an Ambulance Transformation Project which when completed will see the implementation of the governance structure, legislative capacity and technology necessary to effectively monitor the road ambulance program to ensure the intended results are achieved.*

    *Of the ten recommendations in the Fitch Report the Department has implemented or is currently implementing five of the recommendations and assessment continues on the five remaining medium and longer term recommendations. The Department has hired a Management Analyst whose responsibility is to monitor ambulance program expenditures and activities. The analyst is utilizing the newly installed Automatic Vehicle Location systems to monitor operator response performance and ambulance efficiency.*

## Eastern Regional Health Authority Response

2. ***The Eastern Regional Health Authority should ensure that the road ambulance services provided by private and community based operators for the Eastern Regional Health Authority meet the skill levels required by the Department of Health and Community Services. In instances in which operators demonstrate that they must temporarily employ attendants with less than the required skill levels, the Eastern Regional Health Authority and the Department of Health and Community Services should ensure there is adequate documentation for relief under the "Best Efforts" policy.***

    *Eastern Health will work with the Department to develop a methodology to achieve this recommendation. Eastern Health appreciates that recommendations from previous reports as commissioned by the Department and Eastern Health, contain the recommended path forward to reach this goal.*

6. ***Eastern Regional Health Authority should ensure targets that the Department of Health and Community Services sets are being monitored for the eastern region of the Province.***

    *Eastern Health will work with the Department to implement the systems and processes required to achieve this recommendation. The fundamental component to ensuring these response time targets is the establishment of a central ambulance dispatch center as was*

*recommended in the Departments 2013 consultant report. The Department has subsequently contracted a consultant to review this specific deliverable and Eastern Health has been working cooperatively with that project and will continue to support the objective a Provincial central ambulance dispatch center based on advice of the pending consultant report.*

*At this time the Department has approved the installation of Automatic Vehicle Locator (AVL) GPS Technology on all ambulances Province-wide. This is one tool that will aid Regional Health Authorities in gathering data for monitoring and inspection of ambulance response times throughout the Province.*

***7. The Eastern Regional Health Authority should ensure that Patient Care Reports are included in patient medical records and that the Patient Care Reports are not altered after the patient transports are completed.***

*In respect of the private and community ambulance operator PCR's not found on patients charts, for some of those patients the final destination may not have been to hospital facilities (i.e.: return home, outside appointments, other facilities outside of Eastern Health, refusal of transport, etc.), and in such cases a PCR would not be contained within the hospital record.*

*Eastern Health is concerned with the reported inaccuracies of private and community ambulance operator PCR's between the patient chart and final documentation submission to Finance, as well as, the potential impact of missing documentation in the medical record. To resolve these issues the implementation of an Electronic Patient Care Reporting (ePCR) system will avoid these issues and improve communication of pertinent medical information in a timely fashion, enhance quality assurance auditing, and provide more reliable and accurate data for billing and operational planning of ambulance services. Support for an ePCR system was outlined in the 2013 Department consultant report, Eastern Health's 2015 consultant report, and is being further analyzed in the pending report on central ambulance dispatch through the Department which is expected to provide further support for ePCR. Eastern Health will cooperate with the Department on advancing the implementation of a Province-wide ePCR system.*

***11. The Eastern Regional Health Authority should have systems and processes in place to effectively monitor the day-to-day operations of the road ambulance services provided by base hospitals and private and community operators, and their compliance with Department of Health and Community Services policy.***

*Eastern Health agrees with this recommendation and supports achieving this goal. Eastern Health recognizes this task will require significant work due to the magnitude of ambulance services within Eastern Health which comprise more than thirty bases and perform two thirds of all road ambulance transports for the Province. Ambulance services operated by Eastern Health in St John's and Carbonear perform more than one-third of all transports in the Province, of which nearly 80% are emergency service delivery. Eastern Health will collaborate with the Department on establishing the resources needed to realize this recommendation.*

*These systems and processes have been outlined in previous consultant reports. Specifically, establishing the central ambulance dispatch center with associated human and technology resources such as a modern Computer Aided Dispatch (CAD) system will be core to realizing this capability. The present implementation of the AVL-GPS ambulance tracking technology will enhance the operational awareness of road ambulance services for all Regional Health Authorities, and a sophisticated ePCR system, comparable to other Canadian jurisdictions, will be an additional valuable tool in monitoring day-to-day operations of the ambulance system. The establishment of these tools and resources in combination can safeguard the public interest by providing the Regional Health Authorities and the Department real-time automated data and control to ensure a highly effective and efficient ambulance system.*

**PART 3.5**

# DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

## SALARIED PHYSICIANS

# Summary


## Introduction

The Province's 1,200 physicians are paid in one of three payment arrangements, salaried, fee-for-service or alternate payment plan and 33% of these physicians are salaried. Expenditures for salaried physicians in 2015 were $120.4 million.

Oversight of salaried physicians is a shared responsibility between the Department of Health and Community Services, the Regional Health Authorities and Memorial University of Newfoundland.

The *Medical Care Insurance Act* provides the Department of Health and Community Services with the legislative authority to supervise, direct and control health care programs, as well as remunerate physicians for their services.

The Department of Health and Community Services' Physician Services Division approves salaried physician hiring requests and is responsible for developing and implementing guidelines and procedures for salaried physicians. The Physician Services Division developed the *Salaried Physicians Quick Reference Guidelines*. These guidelines specify the roles and responsibilities as well as the process to be followed when hiring salaried physicians.

Under the *Regional Health Authorities Act*, the Regional Health Authorities are responsible for the regional delivery and administration of health and community services. The Regional Health Authorities are responsible for the clinical and administrative processes relating to salaried physicians.

Memorial University of Newfoundland's Faculty of Medicine is responsible for the academic duties of all salaried physicians with academic appointments. The clinical work performed within the Family Practice Program in St. John's is a shared responsibility between Eastern Health and the Faculty of Medicine.

## Objectives

The objectives of our audit were to determine whether:

1. The Regional Health Authorities and Memorial University of Newfoundland effectively assess the performance of salaried physicians; and

2. The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland, through their policies and procedures, effectively manage the hiring of salaried physicians.

## Scope

To assess the effectiveness of salaried physician performance assessment, we selected samples of physicians employed as at September 29, 2015. To assess the effectiveness of the salaried physician hiring process, our sample covered the period April 1, 2006 to September 29, 2015. All samples were non-statistical and random. As part of our audit procedures, we also interviewed senior management and medical program leaders.

Our scope did not include physicians paid through fee-for-service or alternate payment plan arrangements.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in May 2016.

## Importance to Newfoundlanders and Labradorians

Given the competing demand for health care dollars and the significant amount of money being spent on salaried physicians, it is important that the Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland know whether they are receiving value-for-money from salaried physicians. As a result, it is critical that the hiring of salaried physicians be evidence-based and that the workloads of salaried physicians be formally measured.

## Conclusions

**Objective 1**

The Regional Health Authorities and Memorial University of Newfoundland do not effectively assess the performance of salaried physicians.

**Objective 2**

The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland are not effectively managing the hiring of salaried physicians.

## Findings

**Accountability**

*Performance Appraisals*

1. There is no province-wide standard relating to how often salaried physicians are to be formally evaluated.

2. The Regional Health Authorities do not conduct performance appraisals of salaried physicians in accordance with internal policies.

*Workload Requirements*

3. The ability of the Regional Health Authorities to ensure salaried physicians are accountable is limited because physician job descriptions do not adequately specify detailed workload requirements.

*Physician Performance Reporting Measures*

4. The Regional Health Authorities and Memorial University of Newfoundland do not have adequate systems in place to monitor salaried physician performance against workload requirements.

**Hiring**

*Regional Health Authority and Memorial University of Newfoundland Compliance with the Salaried Physicians Quick Reference Guidelines and the Memorandum of Agreement*

5. Regional Health Authorities and Memorial University of Newfoundland could not provide evidence that salaried physician hiring requests were always submitted to the Department of Health and Community Services as required.

6. Regional Health Authorities did not always submit salaried physician hiring requests to the Department of Health and Community Services prior to physicians starting work.

7. Regional Health Authorities and Memorial University of Newfoundland hired salaried physicians without obtaining prior Departmental approval as required.

8. Labrador-Grenfell Health could not provide an official record of clinical experience for one of the salaried physician files examined; therefore, we were unable to determine whether the physician had been placed on the correct pay step.

9. Two salaried physicians employed at Labrador-Grenfell Health were initially paid at the incorrect pay step.

10. Salaried physicians working in both a clinical and academic capacity receive annual remuneration that exceeds what is required to be paid per the Memorandum of Agreement between the Province and the Newfoundland and Labrador Medical Association by 14%. This additional remuneration relates to an unsupported payment in lieu of benefits.

11. The Department of Health and Community Services was unable to determine whether approval for the 14% in lieu of benefits payment to salaried physicians working in both a clinical and academic capacity was provided.

12. Salaried physicians working in both a clinical and academic capacity receive greater compensation than full-time clinical salaried physicians. Memorial University of Newfoundland and the Department of Health and Community Services indicated that this additional remuneration paid to salaried physicians working in both a clinical and academic capacity compensates for the extra hours worked over and above what is specified in their job descriptions.

13. Regional Health Authorities and Memorial University of Newfoundland allowed salaried physicians to start work prior to signing an employment contract.

14. 22 of the 45 salaried physicians we reviewed are still working without a signed employment contract.

*Needs Analysis*

15. The Department of Health and Community Services does not require Regional Health Authorities and Memorial University of Newfoundland to submit needs-based justifications supporting salaried physician hiring requests.

*Department of Health and Community Services Compliance with Guidelines*

16. In 8 of the 45 salaried physician files examined, the Department of Health and Community Services did not approve the hiring of the physician.

*Department of Health and Community Services Policies and Procedures*

17. The *Salaried Physicians Quick Reference Guidelines* are outdated and are not consistent with the policies and processes of Eastern Health and the Department of Health and Community Services.

## Recommendations

1. The Department of Health and Community Services should consider development of province-wide performance appraisal standards specifying how often physicians employed at the Regional Health Authorities and Memorial University of Newfoundland are to be formally assessed.

2. The Regional Health Authorities should conduct performance appraisals in accordance with their internal policies.

3. The Regional Health Authorities should develop and implement detailed workload requirements for salaried physicians.

4. The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should develop an accountability system to track the level of service provided by salaried physicians.

5. The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should ensure they comply with the *Salaried Physicians Quick Reference Guidelines* when hiring salaried physicians.

6. The Department of Health and Community Services should assess the remuneration policy of salaried physicians working in both a clinical and academic capacity to ensure it reflects appropriate value.

7. The Department of Health and Community Services should require the Regional Health Authorities and Memorial University of Newfoundland to provide well documented, needs-based justifications for each salaried physician hiring request and the Department should base their approval decision on this needs-based information.

8. The Department of Health and Community Services should update the *Salaried Physicians Quick Reference Guidelines* to reflect the current hiring processes in place at the Regional Health Authorities and the Department.

## Importance of implementing these recommendations

Implementing these recommendations is an important step in improving salaried physician accountability. These recommendations will enable the Province to better determine if they are receiving an adequate level of service from salaried physicians relative to the amount of health care dollars provided. As well, implementing these recommendations will enhance the Department of Health and Community Services and Regional Health Authorities' awareness of the clinical necessity of salaried physician positions throughout the Province.

# Objectives and Scope

The objectives of our audit were to determine whether:

1. The Regional Health Authorities (RHAs) and Memorial University of Newfoundland (MUN) effectively assess the performance of salaried physicians; and

2. The Department of Health and Community Services (the Department), RHAs and MUN, through their policies and procedures, effectively manage the hiring of salaried physicians.

Criteria were developed specifically for this audit based upon relevant legislation, policies and procedures, our related work, reviews of literature including reports of other legislative auditors, and consultations with management. The criteria were accepted as suitable by senior management of the Department, the RHAs and MUN.

## Scope

To assess the effectiveness of salaried physician performance assessment, we selected samples of physicians employed as at September 29, 2015. To assess the effectiveness of the salaried physician hiring process, our sample covered the period April 1, 2006 to September 29, 2015. All samples were non-statistical and random. As part of our audit procedures, we also interviewed senior management and medical program leaders.

Our scope did not include physicians paid through fee-for-service or alternate payment plan arrangements.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in May 2016.

# Background

The 1,200 physicians practicing in the Province are an integral component of the health system. Physicians are paid in one of three ways:

1. Salaried - Payments are made bi-weekly in accordance with the salaries set in the Memorandum of Agreement (MOA) between the Province and the Newfoundland and Labrador Medical Association (NLMA). Salaried physicians can be employees of a RHA or MUN.

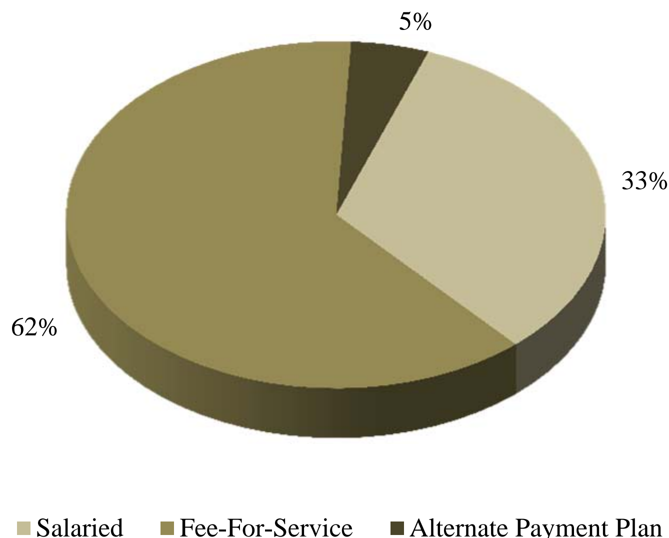
2. Fee-for-Service (FFS) - Payments are made for each service performed by the physician. Claims for payment are processed and paid in accordance with approved FFS rates.

3. Alternate Payment Plan (APP) - The payment method contains elements of both the FFS and the salaried payment arrangements. The payment a physician receives is supported by individual contracts with each physician and are based on block funding arrangements administered by the Department.

33% of the Province's physicians are salaried.

**Chart 1**

**Salaried Physicians**
**Percentage of Physicians by Payment Arrangement**
**As at March 31, 2015**

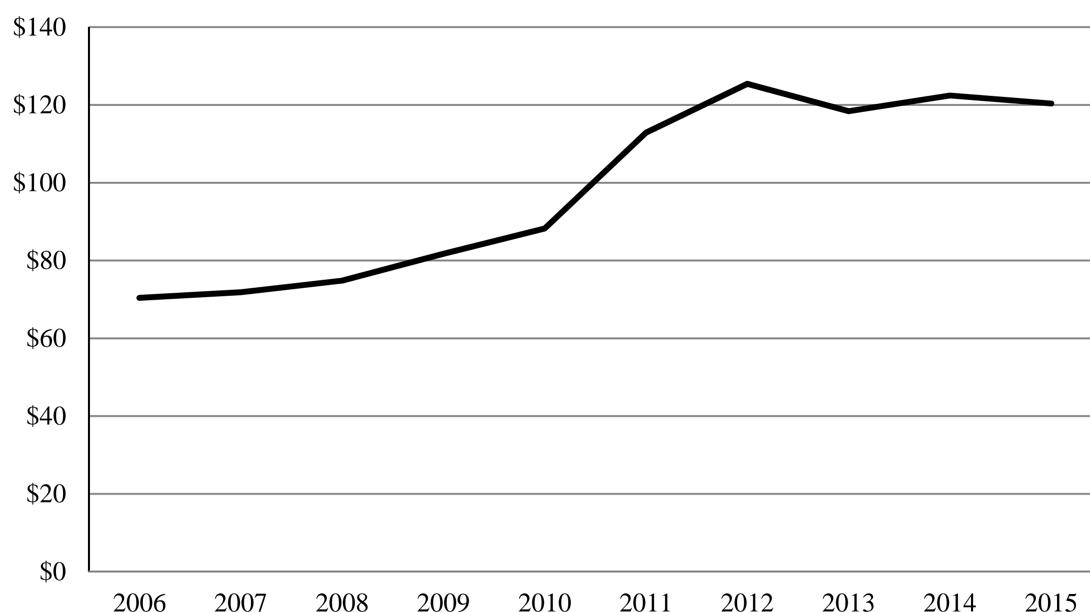



Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services (unaudited).

Salaried payment arrangements are a key component to rural health care delivery. Initially, this payment method was used to attract physicians to areas where the smaller populations did not necessarily make it feasible to be compensated through a FFS arrangement.

**Chart 2**

**Salaried Physicians**
**Annual Salaried Physician Expenditures**
**(Millions)**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services (unaudited).

Expenditures for salaried physicians increased from $70.4 million in 2006 to $120.4 million by 2015, an increase of 71% over nine years.

**Table 1**

**Salaried Physicians**
**Salaried Physician Increases between 2006 and 2015**

| RHA | Number of Salaried Physicians | | |
|---|---|---|---|
| | **2006** | **2015** | **Percentage Change** |
| Eastern Health (including MUN) | 190 | 248 | 31% |
| Central Health | 60 | 46 | -23% |
| Western Health | 46 | 57 | 24% |
| Labrador-Grenfell Health | 39 | 43 | 10% |
| **Total** | **335** | **394** | **18%** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Department of Health and Community Services (unaudited).

The total number of salaried physicians increased from 2006 to 2015 by 18%. The increase in expenditure relative to the increase in the number of physicians is mainly attributable to negotiated salary increases with the NLMA.

Oversight of salaried physicians is a shared responsibility between the Department, the RHAs and MUN.

The Department

The *Medical Care Insurance Act* provides the Department with the legislative authority to supervise, direct and control health care programs, as well as remunerate physicians for their services.

Ensuring that physician services are planned in accordance with the needs of the population and the fiscal capacity of the health system is the responsibility of the Province. This includes determining the need for and placement of physicians.

The Department's Physician Services Division (the Division) approves salaried physician hiring requests and is responsible for developing and implementing guidelines and procedures for salaried, FFS and APP physicians. The Division developed the *Salaried Physicians Quick Reference Guidelines* (the Guidelines). The Guidelines specify the roles and responsibilities as well as the process to be followed when hiring salaried physicians.

RHAs

Under the *Regional Health Authorities Act*, the RHAs are responsible for the regional delivery and administration of health and community services. The RHAs are responsible for the clinical and administrative processes relating to salaried physicians.

MUN

The Faculty of Medicine is responsible for the academic duties of all salaried physicians with academic appointments. The clinical work performed within the Family Practice Program in St. John's is a shared responsibility between Eastern Health and the Faculty of Medicine.

# Detailed Observations

## 1. Accountability

**Objective**

To determine whether the RHAs and MUN effectively assess the performance of salaried physicians.

### Conclusion

The Regional Health Authorities and Memorial University of Newfoundland do not effectively assess the performance of salaried physicians.

**Overview**

Measuring performance is fundamental to achieving accountability. Salaried physicians are an important component of the health system and account for $120 million in annual expenditures. Our audit examined the accountability systems governing salaried physicians.

We assessed the RHAs and MUN against the following criteria:

A. RHAs and MUN conduct performance appraisals in accordance with internal policies and procedures.

B. Physician job descriptions specify detailed workload requirements.

C. RHAs and MUN conduct reviews of salaried physicians to determine if workload requirements specified in physician job descriptions have been met.

## 1A. Performance Appraisals

### Introduction

The internal policies and procedures of the RHAs and MUN require that all salaried physicians be formally evaluated. Eastern Health policy requires performance appraisals to be conducted every two years, while the other RHAs and MUN require performance appraisals annually.

### Performance Appraisals Not Conducted Consistently and in Accordance with Policies

We selected a random sample of 50 salaried physician files to determine whether performance appraisals were completed in accordance with required policies and procedures during the two year period ending September 29, 2015.

**Table 2**

**Salaried Physicians**
**Performance Appraisal Compliance**
**During the Two Year Period Ending September 29, 2015**

| Employer | Physician Files Examined | Performance Appraisals Required | Performance Appraisals Completed |
|---|---|---|---|
| Eastern Health | 17 | 17 | 15 |
| Central Health | 11 | 18 | 9 |
| Western Health | 10 | 19 | 4 |
| Labrador-Grenfell Health | 9 | 18 | 0 |
| MUN | 3 | 5 | 5 |
| **Total** | **50** | **77** | **33** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Regional Health Authorities and Memorial University of Newfoundland (unaudited).

Although Labrador-Grenfell Health requires that a performance appraisal be conducted annually, physicians are currently not being evaluated.

Physicians at Central Health and Western Health did not receive the required number of performance appraisals over the two-year period. In some instances, physicians were evaluated only once and in other instances, they were not evaluated.

In addition, there is no province-wide standard relating to how often physicians are to be formally evaluated.

By not evaluating physicians as required, the RHAs' ability to effectively manage individual physician performance is diminished.

## Findings

1. There is no province-wide standard relating to how often salaried physicians are to be formally evaluated.

2. The Regional Health Authorities do not conduct performance appraisals of salaried physicians in accordance with internal policies.

## 1B. Workload Requirements

### Introduction

Ensuring that detailed workload requirements are included in physician job descriptions is a critical step in the hiring of salaried physicians, as detailed work expectations assist in promoting quality and efficiency.

Recognizing the importance of having in place physician job descriptions that accurately reflect duties and responsibilities, the Department made it a requirement in 2006 that all new physicians hired have a job description. Although many physicians were hired without a job description before April 1, 2006, RHA bylaws require that physicians be reappointed every three to five years. As part of this reappointment process, clinical responsibilities are required to be reviewed. Therefore, job descriptions formalizing the clinical responsibilities and workload requirements of physicians hired before April 1, 2006 should be in place.

A physician's job description should specify weekly working hours, daily workload metrics and where applicable, number of clinics per week. Daily workload metrics should specify the number of patients seen per day, clinic hours, or the average number of cases processed daily.

### Job Descriptions Do Not Contain Workload Requirements

We requested the job descriptions for 65 physicians and identified the following:

- In 19 of the 65 physician files examined, a physician job description was not provided.

- In 12 of the 46 job descriptions examined, the RHAs did not specify the number of weekly hours the physician must work.

- The 46 job descriptions examined included 5 for pathologists, who are not required to provide clinics. In 25 of the remaining 41 job descriptions provided, the RHAs did not include the number of clinics per week a physician is required to work.

- In 26 of the 46 job descriptions examined, the RHAs did not specify a daily workload requirement.

**Finding**

3. The ability of the Regional Health Authorities to ensure that salaried physicians are accountable is limited because physician job descriptions do not adequately specify detailed workload requirements.

## 1C. Physician Performance Reporting Measures

### Introduction

The medical program leaders of the RHAs and MUN are required to monitor the delivery and quality of medical care. Assessing salaried physician performance is an important step in this process. Therefore, an accountability system that tracks the clinical workload levels of a salaried physician is vital in determining whether workload expectations are being met.

### Workload Levels Not Measured Adequately

There are no dedicated accountability systems in place at the RHAs and MUN to measure physician performance levels. Although there are information systems in place at the RHAs and MUN that track the scheduled workloads of physicians, these systems do not reflect actual physician workload performance. Consequently, they do not provide effective oversight over salaried physicians' clinical workload performance and cannot be relied upon for accountability purposes.

We interviewed the medical program leaders of 64, randomly selected, salaried physicians to determine what alternate procedures were done to assess individual physician performance against work expectations. We found that in most instances, there were no documented processes in place to monitor the workload productivity of salaried physicians. In instances where physician workloads were monitored, there was no indication that these metrics were measured against workload requirements detailed in physician employment contracts.

The Strategic Plan of the Department recognizes the importance of strengthening efficiencies in the provincial health system. Therefore, it is important that the RHAs and MUN address this Departmental goal. By not having effective accountability systems in place to measure the efficiency of salaried physicians, the RHAs and MUN limit their ability to effectively assess salaried physician performance.

**Finding**

4. The Regional Health Authorities and Memorial University of Newfoundland do not have adequate systems in place to monitor salaried physician performance against workload requirements.

## 2. Hiring

**Objective**

To determine whether the Department, RHAs and MUN, through their policies and procedures, effectively manage the hiring of salaried physicians.

### Conclusion

The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland are not effectively managing the hiring of salaried physicians.

**Overview**

Hiring of salaried physicians is a joint responsibility between the Department, the four RHAs and MUN. Given the competing demand for health care funding and the significant amount of money being spent on salaried physicians, it is critical that hiring be evidence-based and in accordance with sound policy.

We assessed the Department, the RHAs and MUN against the following criteria:

A. RHAs and MUN hire salaried physicians in accordance with the requirements of the Guidelines and the MOA.

B. The Department requires RHAs and MUN to prepare a needs analysis supporting a physician resourcing request.

C. The Department complies with the Guidelines when considering salaried physician hiring requests from the RHAs and MUN.

D. The Department has in place policies and procedures governing the approval of salaried physician hiring requests that are updated as required.

## 2A. RHA and MUN Compliance with the Guidelines and the MOA

### Introduction

The RHAs and MUN are required to follow the procedures specified in the Guidelines when hiring salaried physicians. The RHAs are also responsible for ensuring that salaried physician remuneration is in accordance with the MOA.

We selected a sample of 45 salaried physicians from the four RHAs and MUN to assess whether the hiring of the salaried physicians were in compliance with the Guidelines and the MOA.

### Physician Hiring Requests

The Guidelines require the RHAs and MUN to submit physician hiring requests to the Department in a timely manner. This enables the Department to have sufficient time to review the request. However, our examination revealed that:

- In 9 of the 45 physician files examined, the RHAs and MUN could not provide evidence that a physician hiring request was submitted to the Department.

- In 6 of the 45 physician files examined, the RHAs submitted a physician hiring request after the physician had started work.

Not complying with the hiring request requirements contributes to ineffective hiring, as the Department loses control of the hiring process and its ability to make an evidence-based decision on the clinical necessity of the position.

## Findings

5. Regional Health Authorities and Memorial University of Newfoundland could not provide evidence that salaried physician hiring requests were always submitted to the Department of Health and Community Services as required.

6. Regional Health Authorities did not always submit salaried physician hiring requests to the Department of Health and Community Services prior to physicians starting work.

### Physicians Hired Without Departmental Approval

The Guidelines require that the RHAs and MUN obtain Departmental approval prior to hiring physicians.

**Table 3**

**Salaried Physicians**
**Number of Physicians Hired by RHAs and MUN Without Departmental Approval**

| Employer | Physician Files Examined | Physicians Hired Without Prior Departmental Approval |
|---|---|---|
| Eastern Health | 13 | 9 |
| Central Health | 9 | 2 |
| Western Health | 11 | 5 |
| Labrador Grenfell Health | 9 | 7 |
| MUN | 3 | 2 |
| **Total** | **45** | **25** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Regional Health Authorities and Memorial University of Newfoundland (unaudited).

Although the Department ultimately approved the hiring request in most cases, in 25 of the 45 physician files examined, the RHAs and MUN hired the physician prior to obtaining Departmental approval.

## Finding

7. Regional Health Authorities and Memorial University of Newfoundland hired salaried physicians without obtaining prior Departmental approval as required.

**Physicians Paid at Incorrect Pay Step**

The Department determines where a salaried physician will be placed within the MOA pay scale after assessing the previous clinical experience of the physician. It is then the responsibility of the RHAs to ensure that all salaried physicians are paid at the correct level.

Of the 45 physicians included in our sample:

- Labrador-Grenfell Health could not provide the official record of clinical experience for one physician; therefore, we were unable to determine whether the physician had been placed on the correct pay step; and

- Labrador-Grenfell Health hired two salaried physicians without the required approval from the Department and initially paid these physicians at the incorrect pay step. Upon receiving the step assignment from the Department, the initial errors were identified and corrected.

## Findings

8. Labrador-Grenfell Health could not provide an official record of clinical experience for one of the salaried physician files examined; therefore, we were unable to determine whether the physician had been placed on the correct pay step.

9. Two salaried physicians employed at Labrador-Grenfell Health were initially paid at the incorrect pay step.

**Physician Compensation**

Salaried Physicians working in both a clinical and academic capacity receive annual remuneration that exceeds what is required to be paid under the MOA. The remuneration of these physicians is substantially higher than that of full-time clinical salaried physicians. Furthermore, we found that the Department was unable to determine whether approval for this additional remuneration was provided.

As at March 31, 2016, there were approximately 100 salaried physicians working in the Province with both academic responsibilities with MUN's Faculty of Medicine and clinical responsibilities with the RHAs. These salaried physicians are classified as Geographic Full-Time (GFT) physicians and are employees of MUN.

In most cases, 80% of a GFT's time is spent providing clinical care and 20% is devoted to academic responsibilities. MUN compensates GFTs for their academic responsibilities using salary scales for faculty members. The MOA requires that RHAs remunerate GFTs for their clinical work at a rate of 90% of a full-time clinical salary; however, approximately 10% of their clinical pay is required to be paid to MUN to assist in covering administrative costs.

GFTs are entitled to all of the employee benefits provided by MUN, including health and dental benefits as well as membership in the Memorial University Pension Plan, a defined benefit plan. All full-time clinical salaried physicians employed at the RHAs are also entitled to health and dental benefits. Full-time clinical salaried physicians hired after January 1, 2000 are required to become members of the NLMA Group RRSP Plan, a defined contribution plan. However, all eligible full-time clinical salaried physicians hired before this date were provided the opportunity to remain in the Public Service Pension Plan, a defined benefit plan.

Table 4 compares the remuneration, pension and health benefit entitlements of full-time clinical salaried physicians employed at the RHAs to those of GFTs.

**Table 4**

**Salaried Physicians**
**Full-time Clinical and GFT Physicians - Salary and Benefit Entitlement Comparison**

| Benefit Type | Full-time Clinical Physicians | GFT Physicians |
|---|---|---|
| Annual Clinical Salary from RHA | 100% of MOA | 90% of MOA* |
| Payment in Lieu of Benefits | - | 14% of RHA Salary |
| Annual Salary from MUN | - | MUN Salary Scale |
| Employer Pension Contribution | 5% of RHA Salary** | 8.1% / 9.9% of MUN Salary |
| Pension Plan Type | Defined Contribution or Benefit Plan | Defined Benefit |
| Other Benefits | Health and Dental, Group Life | Health and Dental, Group Life |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Memorandum of Agreement, Regional Health Authorities and Memorial University of Newfoundland (unaudited).
*GFT physicians either receive their clinical pay through partnership income as members of the Medical Practice Association or through a Professional Medical Corporation.
**Relates to full-time clinical salaried physicians participating in the NLMA Group RRSP.

As Table 4 shows, GFTs receive an additional 14% of their RHA salary in lieu of benefits from the RHAs. This additional salary, according to the Department, is intended to compensate GFTs for additional pension, health, dental and Group Life benefits they do not receive, as they are not employees of the RHAs. However, this additional salary to GFTs is not in accordance with the MOA and provides GFTs with additional compensation for benefits they already receive from MUN.

Table 5 provides an illustrative example of the annual salary and employer pension contribution benefits received by a full-time clinical salaried physician compared to that received by a GFT physician, who is a professor, at the same pay step within the MOA salary scale. Health and dental benefits are not included, as these benefits are similar under both employment arrangements.

**Table 5**

**Salaried Physicians**
**Compensation Comparison - General Practitioners**

| Compensation Type | Full-time Clinical Physician | GFT Physician |
|---|---|---|
| Annual Clinical Salary from RHA | $181,912 | $163,721 |
| Less: 10% of Clinical Income Payment to MUN | | (16,372) |
| 14% Payment in Lieu of Benefits | | 22,921 |
| Annual Salary from MUN | - | 140,688 |
| Employer Pension Contribution | 9,096 | 13,003 |
| **Total** | **$191,008** | **$323,961** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Regional Health Authorities and Memorial University of Newfoundland (unaudited).

MUN and the Department indicated that GFT physicians receive additional remuneration because GFTs work both in a clinical and academic capacity and are required to provide the same level of on call coverage as full-time clinical physicians. Consequently, GFTs have higher expectations for job performance and output and are therefore required to work in excess of the hours specified in their job descriptions. However, our testing found that GFTs were not required, contractually, to work longer than full-time clinical physicians.

## Findings

10. Salaried physicians working in both a clinical and academic capacity receive annual remuneration that exceeds what is required to be paid per the Memorandum of Agreement between the Province and the Newfoundland and Labrador Medical Association by 14%. This additional remuneration relates to an unsupported payment in lieu of benefits.

11. The Department of Health and Community Services was unable to determine whether approval for the 14% in lieu of benefits payment to salaried physicians working in both a clinical and academic capacity was provided.

12. Salaried physicians working in both a clinical and academic capacity receive greater compensation than full-time clinical salaried physicians. Memorial University of Newfoundland and the Department of Health and Community Services indicated that this additional remuneration paid to salaried physicians working in both a clinical and academic capacity compensates for the extra hours worked over and above what is specified in their job descriptions.

**Employment Contracts Not Signed**

Employment contracts enable the RHAs and MUN to hold physicians accountable to specific detailed workload requirements (i.e. hours of work, number of clinics per week, number of cases processed daily, etc.).

The Guidelines require that an employment contract is comprised of a signed letter of offer and a job description. These documents must be signed by both the physician and employer prior to the physician starting work.

**Table 6**

**Salaried Physicians**
**Number of Physicians Working Without an Employment Contract**

| Employer | Physician Files Examined | Physicians Working Before an Employment Contract was Signed | Physicians Still Working Without a Signed Employment Contract |
|---|---|---|---|
| Eastern Health | 13 | 10 | 8 |
| Central Health | 9 | 8 | 5 |
| Western Health | 11 | 8 | 2 |
| Labrador-Grenfell Health | 9 | 9 | 7 |
| MUN | 3 | 1 | - |
| **Total** | **45** | **36** | **22** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from the Regional Health Authorities and Memorial University of Newfoundland (unaudited).

The RHAs and MUN allowed physicians to start work before employment contracts were signed. Furthermore, some physicians are still working without a signed employment contract.

These instances of non-compliance diminish the ability of the RHAs and MUN to hold physicians accountable for their work performance.

## Findings

13. Regional Health Authorities and Memorial University of Newfoundland allowed salaried physicians to start work prior to signing an employment contract.

14. 22 of the 45 salaried physicians we reviewed are still working without a signed employment contract.

## 2B. Needs Analysis

### Introduction

Hiring physicians is important to all residents of the Province, as it directly impacts the accessibility to medical services. The Department is required to approve all salaried physician hiring requests. Needs-based information should be provided for all physician hiring requests to ensure the Department makes well informed hiring decisions.

We selected a random sample of 45 salaried physicians to assess the level of documentation supporting hiring requests.

### Hiring Decisions Made Without Needs Based Information

The Department does not require the RHAs and MUN to submit a needs-based justification supporting a salaried physician request. Department officials indicated that it is often unnecessary for the RHAs and MUN to submit such information with every physician hiring request for the following reasons:

- Many salaried physician positions are required to be filled in order to provide 24/7 service coverage; and

- Given the relatively small population of the Province, most of the service areas are well understood.

The Department also indicated that it conducts its own preliminary review on each salaried physician hiring request to determine whether the position is needed to cover clinical work volume or to maintain a 24/7 service coverage. However, the Department was unable to provide evidence of these preliminary assessments for most of the 45 physicians in our sample.

Evidence-based decision making is vital when approving physician hiring requests. By not enforcing the requirement that RHAs and MUN justify all hiring requests, the Department diminishes its ability to provide informed hiring approvals.

## Finding

15. The Department of Health and Community Services does not require Regional Health Authorities and Memorial University of Newfoundland to submit needs-based justifications supporting salaried physician hiring requests.

## 2C. Departmental Compliance with Guidelines

**Introduction**

The Department is responsible for making province-wide physician resourcing decisions that promote fair access to physician services and for determining the level of remuneration of salaried physicians. The Guidelines outline what is required of the Department when considering physician hiring requests.

We selected a random sample of 45 salaried physicians to assess Departmental compliance with the Guidelines.

**Departmental Compliance**

In 8 of the 45 physician files examined, the Department did not approve the hiring request; therefore, we were unable to determine whether the Department assigned these physicians to the correct pay step.

### Finding

16. In 8 of the 45 salaried physician files examined, the Department of Health and Community Services did not approve the hiring of the physician.

## 2D. Departmental Policies and Procedures

**Introduction**

To ensure the effective hiring of salaried physicians, the Department should have in place guidelines that require well documented hiring requests. The Guidelines detail the procedures the RHAs, MUN and the Department must follow when hiring physicians.

**Guidelines Not Updated**

The Guidelines specify the activities required to be completed when hiring a physician. However, the Guidelines have not been updated since 2006 and are not consistent with certain current policies and processes of the RHAs, MUN and the Department. For example:

- The Salaried Physicians Approval Committee, which approved all physician hiring requests, was disbanded in 2009. The Department has not yet updated the Guidelines to reflect the transfer of the Committee's responsibilities to the Director of Physician Services.

- The Guidelines require that a salaried physician have a performance appraisal conducted annually; however, the *Eastern Health Bylaws Respecting Medical Staff* state that active medical staff shall have a review every two years.

## Finding

17. The *Salaried Physicians Quick Reference Guidelines* are outdated and are not consistent with the policies and processes of Eastern Health and the Department of Health and Community Services.

# Recommendations

1. The Department of Health and Community Services should consider development of province-wide performance appraisal standards specifying how often physicians employed at the Regional Health Authorities and Memorial University of Newfoundland are to be formally assessed.

2. The Regional Health Authorities should conduct performance appraisals in accordance with their internal policies.

3. The Regional Health Authorities should develop and implement detailed workload requirements for salaried physicians.

4. The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should develop an accountability system to track the level of service provided by salaried physicians.

5. The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should ensure they comply with the *Salaried Physicians Quick Reference Guidelines* when hiring salaried physicians.

6. The Department of Health and Community Services should assess the remuneration policy of salaried physicians working in both a clinical and academic capacity to ensure it reflects appropriate value.

7. The Department of Health and Community Services should require the Regional Health Authorities and the Memorial University of Newfoundland to provide well documented, needs-based justifications for each salaried physician hiring request and the Department should base their approval decision on this needs-based information.

8. The Department of Health and Community Services should update the *Salaried Physicians Quick Reference Guidelines* to reflect the current hiring processes in place at the Regional Health Authorities and the Department.

# Department of Health and Community Services' Response

***Recommendation #1***
*The Department of Health and Community Services should consider development of province-wide performance appraisal standards specifying how often physicians employed at the Regional Health Authorities and Memorial University of Newfoundland are to be formally assessed.*

***Response:***
*For the purposes of this report it is the department's understanding that the focus is on salaried physicians and that the assessment being discussed is on workload measurement activities as part of performance. It is agreed that workload measurement can be better monitored and the department has been working in collaboration with the RHAs and the NLMA on building appropriate job descriptions with embedded workload performance metrics that can be easily monitored.*

***Recommendation #4***
*The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should develop an accountability system to track the level of service provided by salaried physicians.*

***Response:***
*The Department does agree that the service level provided by salaried physicians should be monitored. In fact the Department is continuing to work with the RHAs on this. It is recognized that while this appears simplistic in concept it is more complicated on an individual site/individual physician perspective. Physicians perform a variety of activities that include outpatient care, inpatient care, on call, and in addition many services that vary from specialty to specialty including surgery, diagnostic procedures, obstetrical care, etc. There are many metrics that can be developed to reflect the services but these will vary greatly between the various specialists, within the various specialists depending on the site and between sites. The Department has taken the approach that in collaboration with the RHAs formalized generic job descriptions are being developed for each of the specialties. This will provide standardization while allowing flexibility in the workload that will be quantified in the metrics. As noted this will allow the nuances of each site/specialty to be addressed while maintaining provincial consistency.*

***Recommendation #5***
*The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should ensure they comply with the* Salaried Physicians Quick Reference Guidelines *when hiring salaried physicians.*

***Response:***
*The Department had advised the AG's staff that a number of policies had changed since this document was produced in 2006 and acknowledges that the* Salaried Physicians Quick Reference Guidelines *needs to be updated to reflect these changes.*

***Recommendation #6***
*The Department of Health and Community Services should assess the remuneration policy of salaried physicians working in both a clinical and academic capacity to ensure it reflects appropriate value.*

***Response:***
*The Department will continue to work with the RHAs and the Faculty of Medicine to review and adjust current practices that recognize these elements. However, it is standard policy that should a salaried physician wish to be provided an individual service contract that payment in lieu of benefits is provided. At the same time it is recognized that as salaried physicians with fulltime academic appointments receive health benefits as part of their academic salary. The Department does have concerns with the notion articulated in this report that unapproved, excess physician compensation was provided to physicians who are in receipt of both clinical and academic compensation. This is not identified in the Memorandum of Agreement with the NLMA as this agreement does not address academic compensation.*

***Recommendation #7***
*The Department of Health and Community Services should require the Regional Health Authorities and Memorial University of Newfoundland to provide well-documented, needs-based justifications for each salaried physician hiring request and the Department should base their approval decision on this needs-based information.*

***Response:***
*While it is appreciated that staff hiring would be based on a needs-based assessment it is evident in many salaried positions that such needs had already been identified in that it has been determined that a 24/7 service is required. Examples were given of 2-4 physician practices where it is the requirement for a 24/7 service that dictates the number of salaried physicians needed and not patient volumes or other service volumes. In areas where the requirement to fill a position is not based on the need to have a critical mass to provide 24/7 service the Department currently engages in a process that requires the RHA to provide evidence of that need. The Department will ensure this process is well-documented in the future.*

***Recommendation #8***
*The Department of Health and Community Services should update the* Salaried Physicians Quick Reference Guidelines *to reflect the current hiring processes in place at the Regional Health Authorities and the Department.*

***Response:***
*The Department recognizes the need to update the* Salaried Physicians Quick Reference Guidelines *and will do so as soon as the new MOA with the NLMA is signed. This will ensure that elements of the MOA and current processes/policies of the RHAs and Department are documented properly in these guidelines.*

## Regional Health Authorities' Response

***Recommendation #2***

***The Regional Health Authorities should conduct performance appraisals in accordance with their internal policies.***

*The RHAs acknowledge the importance of demonstrating accountability by conducting regular performance appraisals to assess the performance of salaried physicians and identify opportunities to support continued professional development. As noted in recommendation #1, the RHAs will work with the DOHCS to develop provincial standards as it relates to the performance appraisal process for salaried physicians. Policies within the RHAs will be revised, as necessary to support compliance with provincial standards and consistency across the RHAs. As well, processes will be established within the RHAs to ensure performance appraisals are being conducted in compliance with regional policies.*

***Recommendation #3***

***The Regional Health Authorities should develop and implement detailed workload requirements for salaried physicians.***

*The RHAs acknowledge that the inclusion of detailed workload requirements on salaried physician job descriptions can enhance the accountability between the RHA and the physician. To function effectively as an accountability mechanism the workload metrics must be specific, measureable, achievable, reasonable and timely. As noted in finding #4, the RHAs do not currently have adequate systems in place to monitor salaried physician performance against workload requirements.*

*The development of workload requirements, measurement systems and reporting processes need to happen in tandem to add value to the accountability process and impact the efficiency of service delivery.*

*The RHA's will work collectively with the DOHCS to develop workload requirements and incorporate them into job descriptions as a component of a comprehensive workload measurement strategy.*

***Recommendation #4***

***The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should develop an accountability system to track the level of service provided by salaried physicians.***

*The RHAs acknowledge the importance of having an established system to track the level of service provided by salaried physicians. However, it is should be recognized that the roles and responsibilities of salaried physicians is highly dependent on a number of factors including but not limited to geographical location, site specific job responsibilities and caseload, specialty, on*

*call duties, and complexity of patients. The RHAs will work in collaboration with the DOHCS to develop generic job descriptions for individual specialties that incorporates workload measurement and supports consistency across the RHAs.*

***Recommendation #5***

***The Department of Health and Community Services, Regional Health Authorities and Memorial University of Newfoundland should ensure they comply with the* Salaried Physicians Quick Reference Guidelines *when hiring salaried physicians.***

*The RHAs acknowledge the importance of ensuring compliance with the* Salaried Physicians Quick Reference Guidelines *when hiring salaried physicians. As identified in recommendation #8, the RHAs support the review and updating of the Quick Reference Guidelines. The RHAs will work with the DOHCS to update the* Salaried Physicians Quick Reference Guidelines *to reflect the current hiring processes in place within the RHAs and the DOHCS.*

## Memorial University of Newfoundland's Response

*Recommendation 4: The Faculty of Medicine has an annual review system in place to track the level of service provided by GFT physicians. This system allows us to review academic service for all GFT specialist physicians, and both academic and clinical service for Family Medicine physicians. However, we will review our practices to explore opportunities to collaborate with the RHAs and the Department to develop a clearer matrix in this regard.*

*Recommendation 5: Memorial University's Faculty of Medicine will continue to follow established protocols before hiring and will follow the* Salaried Physicians Quick Reference Guidelines *in hiring of salaried physicians. We have a process in place which requires that letters of appointment are signed by the Provost before the start date of the GFT physician.*

# PART 3.6

# DEPARTMENT OF MUNICIPAL AFFAIRS

# FIRE AND EMERGENCY SERVICES - NEWFOUNDLAND AND LABRADOR

# Summary

## Introduction

The mandate of Fire and Emergency Services – Newfoundland and Labrador is to develop and maintain a fire and emergency management system in Newfoundland and Labrador to mitigate against, prepare for, respond to and recover from fires and other emergencies.

Fire and Emergency Services – Newfoundland and Labrador manages and/or supports any large scale emergency or disaster and coordinates the activities and operations of all responders to the event. Fire and Emergency Services – Newfoundland and Labrador also assists municipalities with localized emergencies and disasters.

**Municipal**

One of the roles of Fire and Emergency Services – Newfoundland and Labrador is to encourage and assist municipalities in the creation of their Municipal Emergency Management Plans. Fire and Emergency Services – Newfoundland and Labrador provides guidance and templates on which Municipal Emergency Management Plans are based. Once Municipal Emergency Management Plans are drafted, Fire and Emergency Services – Newfoundland and Labrador must give approval before plans can be adopted by municipalities.

Fire and Emergency Services – Newfoundland and Labrador uses the AMANDA system to track the status of Municipal Emergency Management Plans and to document contact between Fire and Emergency Services – Newfoundland and Labrador representatives and municipalities. Additionally, the AMANDA system is used to store electronic copies of approved Municipal Emergency Management Plans.

**Provincial**

Fire and Emergency Services – Newfoundland and Labrador is also responsible for the creation of the Provincial Emergency Management Plan, which identifies and directs the Provincial Government’s approach to ensuring appropriate preparedness, response and recovery strategies are in place and tested, describes the Province’s emergency management system and articulates how the Provincial Government will connect with and support all partners in a risk-based, all hazards focused emergency management system, including in the event of a Province-wide emergency.

**Departments**

Fire and Emergency Services – Newfoundland and Labrador is responsible for the development and maintenance of a Government Business Continuity Plan. Fire and Emergency Services – Newfoundland and Labrador accomplishes this by requiring the creation of individual Business Continuity Plans by Government departments. Fire and Emergency Services – Newfoundland and Labrador guides the creation of the department Business Continuity Plans and combines the most crucial elements of these to create the Government Business Continuity Plan.

## Objectives

The objectives of our audit were to determine whether Fire and Emergency Services – Newfoundland and Labrador:

1. Is providing effective oversight of Municipal Emergency Management Plans in accordance with the *Emergency Services Act*;

2. Has developed and maintained the Provincial Emergency Management Plan in accordance with the *Emergency Services Act*; and

3. Is providing effective oversight of department Business Continuity Plans in accordance with the *Emergency Services Act*.

Criteria were developed specifically for this audit based upon the *Emergency Services Act,* Fire and Emergency Services – Newfoundland and Labrador policies and procedures, reviews of literature including reports of other legislative auditors, and consultations with Fire and Emergency Services – Newfoundland and Labrador staff. The criteria were accepted as suitable by the senior management of Fire and Emergency Services – Newfoundland and Labrador.

## Scope

Our audit covered the period January 1, 2012 to December 31, 2015. Our audit included a review of the *Emergency Services Act* and Fire and Emergency Services – Newfoundland and Labrador guidance and templates for Municipal Emergency Management Plans and department Business Continuity Plans. We compared Fire and Emergency Services – Newfoundland and Labrador guidance and practice to best practice. Business Continuity Plans examined include only those of the 26 departments required by Government to be incorporated into the Government Business Continuity Plan.

We analyzed and used data related to Municipal Emergency Management Plans and department Business Continuity Plans to assist with our audit procedures. We conducted interviews with Fire and Emergency Services – Newfoundland and Labrador officials. We inspected a sample of Municipal Emergency Management Plans, the Provincial Emergency Management Plan and all Business Continuity Plans. Our sample selection was non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in March 2016.

## Importance to Newfoundlanders and Labradorians

Municipal Emergency Management Plans, the Provincial Emergency Management Plan and the Government and department Business Continuity Plans are crucial components in the emergency management of the Province. Without effective oversight of these plans, there could be a significant public safety risk that municipalities or the Province would not be prepared to effectively respond to an emergency, or that in the case of an emergency, Government would not be able to continue to provide services to the public.

## Conclusions

**Objective 1**

Fire and Emergency Services - Newfoundland and Labrador is providing effective oversight of Municipal Emergency Management Plans in accordance with the *Emergency Services Act*. However, Municipal Emergency Management Plans are not always being updated nor tested annually and the Municipal Emergency Management Plans of a number of smaller municipalities have been in progress for a significant amount of time.

**Objective 2**

Fire and Emergency Services - Newfoundland and Labrador has developed and maintained the Provincial Emergency Management Plan in accordance with the *Emergency Services Act*.

**Objective 3**

Fire and Emergency Services - Newfoundland and Labrador is providing effective oversight of department Business Continuity Plans. However, Fire and Emergency Services - Newfoundland and Labrador has not kept the Government Business Continuity Plan up to date.

## Findings

**Municipal Emergency Management Plans**

*Best Practice*

1. The Municipal Emergency Management Plan template is consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

*Municipal Emergency Management Plan Submission and Review*

2. Of the 443 municipalities (as defined in the *Emergency Services Act*; see Section 1, Municipal Emergency Management Plans, of this report) in the Province, 300 have an approved Municipal Emergency Management Plan in place, as required by legislation. This represents 92% of the population of the Province. 143 municipalities do not have an approved Municipal Emergency Management Plan in place, as required by legislation, representing 8% of the population of the Province.

3. Fire and Emergency Services - Newfoundland and Labrador provided effective review of all Municipal Emergency Management Plans sampled.

4. While the *Emergency Services Act* required all Municipal Emergency Management Plans to be approved and adopted by May 2012, there were 127 Municipal Emergency Management Plans that were still in progress at December 31, 2015. Of these, 87 municipalities had Municipal Emergency Management Plans that had been in progress for at least four years.

*Monitoring of Municipal Emergency Management Plans*

5. 25 of the 31 Municipal Emergency Management Plans sampled did not meet the Fire and Emergency Services – Newfoundland and Labrador requirement of annual updating.

6. For 14 of the 25 Municipal Emergency Management Plans for which the annual update requirement had not been met, there was no documented contact by Fire and Emergency Services – Newfoundland and Labrador to encourage the required update of the Municipal Emergency Management Plan.

7. Only 20 of 300 municipalities with approved Municipal Emergency Management Plans had tested their Municipal Emergency Management Plans during the scope period of our audit.

**Provincial Emergency Management Plan**

*Provincial Emergency Management Plan Best Practice*

8. The Provincial Emergency Management Plan is consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

*Monitoring of the Provincial Emergency Management Plan*

9. Fire and Emergency Services - Newfoundland and Labrador has met the legislative requirement and best practice of maintaining the Provincial Emergency Management Plan.

*Assessment of the Effectiveness of the Provincial Emergency Management Plan*

10. Fire and Emergency Services - Newfoundland and Labrador is effectively assessing the Provincial Emergency Management Plan.

**Business Continuity Plans**

*Department Business Continuity Plan Consistency with Fire and Emergency Services – Newfoundland and Labrador Guidance*

11. All 26 department Business Continuity Plans are consistent with Fire and Emergency Services - Newfoundland and Labrador guidance on the completion of Business Continuity Plans.

*Monitoring of Department Business Continuity Plans and Inclusion in Government Business Continuity Plan*

12. Of the 26 department Business Continuity Plans that Fire and Emergency Services - Newfoundland and Labrador monitors, four have not been updated according to the timeline set in Fire and Emergency Services - Newfoundland and Labrador guidance.

13. As at December 31, 2015, the Government Business Continuity Plan had not been updated since 2010, therefore it may not contain current information from all departments.

*Effectiveness of Business Continuity Plans*

14. Fire and Emergency Services – Newfoundland and Labrador is assessing the effectiveness of the Government Business Continuity Plan and is facilitating the assessment of the effectiveness of the department Business Continuity Plans.

## Recommendations

1. Fire and Emergency Services - Newfoundland and Labrador should ensure that municipalities are contacted and encouraged to finalize any Municipal Emergency Management Plans that are not yet in place and to update their Municipal Emergency Management Plans in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance. Fire and Emergency Services - Newfoundland and Labrador should ensure that this contact is documented.

2. Fire and Emergency Services - Newfoundland and Labrador should ensure that all municipalities are encouraged to perform tests and debriefs on their Municipal Emergency Management Plans in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance.

3. Fire and Emergency Services - Newfoundland and Labrador should monitor and encourage that all department Business Continuity Plans are updated in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance.

4. Fire and Emergency Services - Newfoundland and Labrador should ensure that the Government Business Continuity Plan is maintained in accordance with the *Emergency Services Act*.

## Importance of implementing these recommendations

If these recommendations are implemented, the emergency management system will strengthen the position of municipalities, the Province and Government to effectively respond to an emergency. This would result in a decreased risk to public safety.

# Objectives and Scope

## Objectives

The objectives of our audit were to determine whether Fire and Emergency Services – Newfoundland and Labrador (FES-NL):

1. Is providing effective oversight of Municipal Emergency Management Plans (Emergency Plans) in accordance with the *Emergency Services Act* (the *Act*);

2. Has developed and maintained the Provincial Emergency Management Plan (PEMP) in accordance with the *Act*; and

3. Is providing effective oversight of department Business Continuity Plans (BCPs) in accordance with the *Act*.

Criteria were developed specifically for this audit based upon the *Act,* FES-NL policies and procedures, reviews of literature including reports of other legislative auditors, and consultations with FES-NL staff. The criteria were accepted as suitable by the senior management of FES-NL.

## Scope

Our audit covered the period January 1, 2012 to December 31, 2015. Our audit included a review of the *Act* and FES-NL guidance and templates for Emergency Plans and department BCPs. We compared FES-NL guidance and practice to best practice. BCPs examined include only those of the 26 departments required by Government to be incorporated into the Government BCP.

We analyzed and used data related to Emergency Plans and department BCPs to assist with our audit procedures. We conducted interviews with FES-NL officials. We inspected a sample of Emergency Plans, the PEMP and all BCPs. Our sample selection was non-statistical and random.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in March 2016.

# Background

The mandate of FES-NL is to develop and maintain a fire and emergency management system in Newfoundland and Labrador to mitigate against, prepare for, respond to and recover from fires and other emergencies.

FES-NL manages and/or supports any large scale emergency or disaster and coordinates the activities and operations of all responders to the event. FES-NL also assists municipalities with localized emergencies and disasters.

**Municipal**

One of the roles of FES-NL is to encourage and assist municipalities in the creation of their Emergency Plans. FES-NL provides guidance and templates on which Emergency Plans are based. Once Emergency Plans are drafted, FES-NL must give approval before plans can be adopted by municipalities.

FES-NL uses the AMANDA system (the System) to track the status of Emergency Plans and to document contact between FES-NL representatives and municipalities. Additionally, the System is used to store electronic copies of approved Emergency Plans.

**Provincial**

FES-NL is also responsible for the creation of the PEMP, which identifies and directs the Provincial Government's approach to ensuring appropriate preparedness, response and recovery strategies are in place and tested, describes the Province's emergency management system and articulates how the Provincial Government will connect with and support all partners in a risk-based, all hazards focused emergency management system, including in the event of a Province-wide emergency.

**Departments**

FES-NL is responsible for the development and maintenance of a Government BCP. FES-NL accomplishes this by requiring the creation of individual BCPs by Government departments. FES-NL guides the creation of the department BCPs and combines the most crucial elements of these to create the Government BCP.

# Detailed Observations

## 1. Municipal Emergency Management Plans

**Objective**

To determine whether FES-NL is providing effective oversight of Emergency Plans in accordance with the *Act.*

### Conclusion

Fire and Emergency Services - Newfoundland and Labrador is providing effective oversight of Municipal Emergency Management Plans in accordance with the *Emergency Services Act*. However, Municipal Emergency Management Plans are not always being updated nor tested annually and the Municipal Emergency Management Plans of a number of smaller municipalities have been in progress for a significant amount of time.

**Overview**

Municipalities are responsible for creating Emergency Plans. FES-NL's role is to provide guidance to municipalities for the creation of Emergency Plans, and FES-NL is responsible for the review and approval of the Emergency Plans.

Communication between FES-NL and municipalities is facilitated by FES-NL Regional Emergency Management Planning Officers (Regional Officers) who assist municipalities, as required, with drafting their Emergency Plans. There are 3.5 Regional Officer positions in Newfoundland and Labrador to serve the regions: Eastern, Central, Western and Labrador.

The *Act* defines a municipality as any "*municipality under the* Municipalities Act, 1999*, the City of St. John's, the City of Mount Pearl and the City of Corner Brook and … includes a local service district and an Inuit community referred to in section 8.2 of the* Labrador Inuit Land Claims Agreement Act." Our report defines a municipality in accordance with the *Act*.

The *Act* states that it is acceptable for two or more municipalities to partner and create a regional Emergency Plan. This is common in regions where there is one larger municipality with services that affect surrounding smaller municipalities, or where there are municipalities sharing services such as a fire department or police.

We assessed FES-NL against the following criteria:

A. FES-NL guidance for Emergency Plans is consistent with best practice.

B. Municipalities have submitted Emergency Plans for review; and FES-NL has reviewed all submitted Emergency Plans to ensure they comply with FES-NL guidance.

C. FES-NL has procedures in place to monitor approved Emergency Plans to assess their effectiveness.

## 1A. Best Practice

### Introduction

FES-NL provides an Emergency Plan template (Template) to municipalities, which provides guidance and outlines information required in an Emergency Plan. Government of Canada publications: An Emergency Management Framework for Canada and Emergency Management Planning Guide are considered best practice regarding emergency management plans for government entities. These documents recommend that Emergency Plans contain the coordination of response and recovery efforts across municipalities, government, first responders and other partners following an emergency. The Template should be consistent with these best practice publications.

### Guidance as Compared to Best Practice

We compared the Template to the best practice publications to determine whether the Template contains all relevant information to allow municipalities to appropriately prepare for and respond to an emergency situation.

We determined that the Template was consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

### Finding

1. The Municipal Emergency Management Plan template is consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

## 1B. Emergency Plan Submission and Review

### Introduction

The *Act* was adopted and became effective in 2009. The *Act* required that all municipalities create and adopt an Emergency Plan by May 2012.

Before an Emergency Plan is adopted, the *Act* requires that FES-NL review the Emergency Plan to confirm it contains all required information and to recommend any necessary changes. Municipalities are required to address the recommendations of FES-NL. The review process of the draft Emergency Plan often involves ongoing consultation between the municipality and FES-NL regarding recommended changes.

Once the final draft of the Emergency Plan is submitted to FES-NL, the Director of Emergency Services reviews it and advises the municipality of approval of the Emergency Plan. The municipality must then formally adopt the Emergency Plan. Once an Emergency Plan is adopted, a copy of the signed Emergency Plan must be forwarded to FES-NL for filing.

**Table 1**

**Fire and Emergency Services – Newfoundland and Labrador**
**Status of Emergency Plans**
**As at December 31, 2015**

| Plan Status | Number of Municipalities | % of Municipalities | Population | % of Population |
|---|---|---|---|---|
| No Action | 16 | 3% | 5,073 | 1% |
| In Progress | 127 | 29% | 37,045 | 7% |
| Plan Approved | 300 | 68% | 461,425 | 92% |
| **Total** | **443** | **100%** | **503,543** | **100%** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from FES-NL AMANDA system.

## Emergency Plans Approved

As at May 2012, only 99 of 443 municipalities had approved Emergency Plans in place as required by the *Act*. However, as at December 31, 2015, FES-NL had approved Emergency Plans for 300 (68%) of the municipalities in the Province, which represents 92% of the population of the Province.

There were 143 municipalities in total that did not have an approved Emergency Plan in place, as required by legislation, as at December 31, 2015. FES-NL is supporting 127 municipalities that were in the process of completing their Emergency Plans and there were still 16 municipalities who had not yet submitted an Emergency Plan for review. FES-NL is making periodic contact to encourage the remaining 16 municipalities to submit Emergency Plans.

## Finding

2. Of the 443 municipalities in the Province, 300 have an approved Municipal Emergency Management Plan in place, as required by legislation. This represents 92% of the population of the Province. 143 municipalities do not have an approved Municipal Emergency Management Plan in place, as required by legislation, representing 8% of the population of the Province.

**Effectiveness of Emergency Plan Reviews**

To determine the effectiveness of the review of Emergency Plans, we randomly chose a sample of 31 approved Emergency Plans covering 40 municipalities in the Province and evaluated the Emergency Plans against FES-NL guidance. All of the Emergency Plans were consistent with FES-NL guidance.

## Finding

3. Fire and Emergency Services - Newfoundland and Labrador provided effective review of all Municipal Emergency Management Plans sampled.

**Emergency Plans in Progress**

Emergency Plans that had been initiated by 127 municipalities either before or during our scope period remained in progress as at December 31, 2015.

**Table 2**

**Fire and Emergency Services - Newfoundland and Labrador**
**Emergency Plans Still In Progress**
**As at December 31, 2015**

| Length of Time in Progress | Number of Municipalities | % of Total |
|---|---|---|
| Less than 1 year | 18 | 14% |
| 1 - 2 years | 11 | 9% |
| 2 - 3 years | 4 | 3% |
| 3 - 4 years | 7 | 6% |
| Over 4 years | 87 | 68% |
| **Total** | **127** | **100%** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from FES-NL AMANDA system.

## Finding

4. While the *Emergency Services Act* required all Municipal Emergency Management Plans to be approved and adopted by May 2012, there were 127 Municipal Emergency Management Plans that were still in progress at December 31, 2015. Of these, 87 municipalities had Municipal Emergency Management Plans that had been in progress for at least four years.

### 1C. Monitoring of Emergency Plans

**Introduction**

After approval and adoption, the *Act* states that Emergency Plans must be periodically reviewed and updated by municipalities. Guidance provided by FES-NL requires that municipalities review and update their Emergency Plans annually and submit any changes to FES-NL for approval.

Municipalities are responsible for reviewing and maintaining Emergency Plans. However, it is the role of FES-NL to monitor that municipalities are completing these reviews and amending their Emergency Plans.

**Emergency Plans Updating**

FES-NL uses the System to determine which Emergency Plans have not been updated in the required timeframe and uses this information to contact municipalities and encourage updates.

We reviewed a sample of 31 Emergency Plans to determine whether, as at December 31, 2015, they had been reviewed and updated within the 12 months prior, in compliance with FES-NL guidance, and if not, what length of time had lapsed since their last update.

**Table 3**

**Fire and Emergency Services - Newfoundland and Labrador**
**Time Since Last Update**
**For Sample of 31 Emergency Plans**
**As at December 31, 2015**

| Time since Last Update | Number of Plans | % of Plans Sampled |
|---|---|---|
| Less than 1 year | 6 | 19% |
| 1 - 2 years | 6 | 19% |
| 2 - 3 years | 5 | 16% |
| 3 - 4 years | 7 | 23% |
| Over 4 years | 7 | 23% |
| **Total** | **31** | **100%** |

Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador based upon data obtained from FES-NL AMANDA system.

As at December 31, 2015, 6 of 31 Emergency Plans sampled had met FES-NL's requirement for updating in the previous 12 months. However, the remaining 25 had not been updated within the required timeframe. 7 of the 31 Emergency Plans had not been updated in more than 4 years.

Without periodic updating, there is a risk that Emergency Plans may not have all current hazards identified or may not contain other current information necessary to effectively respond to and recover from an emergency.

We inspected System documentation to determine the frequency of FES-NL contact with municipalities to encourage them to update their Emergency Plans. We determined that for the 25 Emergency Plans sampled that had not been updated within the required timeframe, there was no documentation for 14 municipalities that FES-NL had made any contact.

## Findings

5. 25 of the 31 Municipal Emergency Management Plans sampled did not meet the Fire and Emergency Services – Newfoundland and Labrador requirement of annual updating.

6. For 14 of the 25 Municipal Emergency Management Plans for which the annual update requirement had not been met, there was no documented contact by Fire and Emergency Services – Newfoundland and Labrador to encourage the required update of the Municipal Emergency Management Plan.

**Testing and Debriefing of Emergency Plans**

To supplement the maintenance of an Emergency Plan, FES-NL encourages municipalities to perform periodic tests of their Emergency Plans. FES-NL encourages and supports these exercises, but the responsibility to initiate and perform them belongs to the municipalities. FES-NL also invites municipalities to participate in any exercises that it performs. FES-NL recommends that any time an Emergency Plan is activated, a post-mortem debrief be completed to identify "what went well", "areas for improvement", and "recommendations."

We requested documentation of any testing and post-mortem debriefs completed on Emergency Plans during the scope period of our audit. FES-NL provided a System report that outlined 27 Emergency Plan tests performed by 20 municipalities during the scope period of our audit. Of the 300 municipalities that have approved Emergency Plans, only 20 municipalities had tested their Emergency Plans. The report indicated that FES-NL had attended debriefs that were completed on all tests performed.

## Finding

7. Only 20 of 300 municipalities with approved Municipal Emergency Management Plans had tested their Municipal Emergency Management Plans during the scope period of our audit.

## 2. Provincial Emergency Management Plan

**Objective**

To determine whether FES-NL has developed and maintained the Provincial Emergency Management Plan (PEMP) in accordance with the *Act.*

### Conclusion

Fire and Emergency Services - Newfoundland and Labrador has developed and maintained the Provincial Emergency Management Plan in accordance with the *Emergency Services Act*.

**Overview**

The PEMP identifies and directs the Province's approach to ensuring preparedness, response and recovery strategies for emergencies are in place and tested. The PEMP describes the Province's emergency management system and defines how the Province will connect with and support all partners in an emergency management system.

We assessed FES-NL against the following criteria:

A. The PEMP is consistent with best practice.

B. FES-NL has procedures in place to monitor and update the PEMP.

C. FES-NL has procedures in place to assess the effectiveness of the PEMP.

### 2A. PEMP Best Practice

**Introduction**

Government of Canada publications: An Emergency Management Framework for Canada and Emergency Management Planning Guide are considered best practice regarding emergency management plans for government entities. These documents recommend that Emergency Plans contain the coordination of response and recovery efforts across municipalities, government, first responders and other partners following an emergency. The PEMP should be consistent with these best practice publications.

**PEMP as Compared to Best Practice**

We inspected the PEMP and compared it to the best practice documents to confirm that the PEMP contains all relevant information to allow the Province to respond appropriately in an emergency situation.

We determined that the PEMP was consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

**Finding**

8. The Provincial Emergency Management Plan is consistent with best practice with respect to the identification of hazards and the response and recovery processes following an emergency.

### 2B. Monitoring of the PEMP

**Introduction**

The *Act* required that FES-NL develop the PEMP by May 2012 and maintain it thereafter. Best practice recommends that emergency plans are periodically reviewed and updated. The PEMP outlines a three year required review and update period.

**PEMP Updating**

The PEMP was originally approved in May of 2012. It was subsequently updated in January of 2014 and, as at March 31, 2016, is undergoing review for an update in 2016. Therefore, FES-NL has met the legislative requirement and best practice for maintaining the PEMP.

**Finding**

9. Fire and Emergency Services - Newfoundland and Labrador has met the legislative requirement and best practice of maintaining the Provincial Emergency Management Plan.

### 2C. Assessment of the Effectiveness of the PEMP

**Introduction**

FES-NL practice requires all Emergency Plans, including the PEMP, to undergo periodic plan validation, which includes developing, conducting and participating in emergency exercise opportunities. Following plan activation from testing or actual emergencies, a post-mortem debrief is also required to be conducted. FES-NL practice requires that the debrief focus on "what went well", "areas for improvement", and "recommendations". The results of these debriefs that apply to the PEMP should be incorporated into the PEMP.

**Testing and Debriefing of the PEMP**

We inspected debriefs resulting from testing and actual emergencies. FES-NL has participated in three exercises and activated the PEMP in response to two actual events. Debriefs were conducted on all five plan activations and recommended improvements were made.

We determined that FES-NL effectively assessed the PEMP and identified and implemented improvements.

**Finding**

10. Fire and Emergency Services - Newfoundland and Labrador is effectively assessing the Provincial Emergency Management Plan.

## 3. Business Continuity Plans

**Objective**

To determine whether FES-NL is providing effective oversight of department Business Continuity Plans (BCPs) in accordance with the *Act*.

### Conclusion

Fire and Emergency Services - Newfoundland and Labrador is providing effective oversight of department Business Continuity Plans. However, Fire and Emergency Services - Newfoundland and Labrador has not kept the Government Business Continuity Plan up to date.

**Overview**

The *Act* requires FES-NL to develop and maintain a BCP for the Government of Newfoundland and Labrador. A BCP contains procedures and guidelines to help recover and restore the Government's essential services to operational status following an emergency or disruptive event.

FES-NL requires that each department maintain their own BCP. FES-NL provided departments with advice, support and training as they developed and validated their BCPs. Additionally, FES-NL is responsible for developing and maintaining a BCP review schedule to ensure that BCPs are being revised and updated on a timely basis.

We assessed FES-NL against the following criteria:

A. Department BCPs are consistent with FES-NL guidance on the completion of BCPs.

B. FES-NL has procedures in place to determine whether department BCPs are maintained and updates are included in the Government BCP.

C. FES-NL has procedures in place to assess the effectiveness of the department and Government BCPs.

### 3A. BCP Consistency with FES-NL Guidance

**Introduction**

FES-NL provides Business Continuity Planning Guidelines (BCP Guidelines) to departments which includes instructions and templates to assist departments in completing BCPs.

The BCP Guidelines instruct departments on how to determine essential services, identify potential threats and risks, identify operational impacts of potential threats, develop a recovery strategy for each essential service and document each of these areas.

**Consistency with Guidance**

We compared all 26 department BCPs to the BCP Guidelines and determined that all required information was included in the BCPs.

## Finding

11. All 26 department Business Continuity Plans are consistent with Fire and Emergency Services - Newfoundland and Labrador guidance on the completion of Business Continuity Plans.

### 3B. Monitoring of Department BCPs and Inclusion in Government BCP

**Introduction**

The Government BCP was created by accumulating the essential services details identified in department BCPs. To maintain the Government BCP, department BCPs must be complete and maintained. Department BCPs are required to be reviewed annually to ensure that the information is current.

FES-NL has indicated that their intended practice is to annually review and update the Government BCP through the following:

- Review current department BCPs to ensure that the most up-to-date information is contained in the Government BCP;
- Consider and update changes in scope and essential services;
- Consultation with the Office of the Chief Information Officer to consider and update changes in computer applications; and
- Consider the results of any exercises, training and best practice standards.

**Departmental BCPs Updating**

We inspected all 26 department BCPs as at December 31, 2015. We determined that 4 of the 26 BCPs had not been updated within the past 12 months as required. The most recent updates for each of these four BCPs ranged from two to five years prior.

**Finding**

12. Of the 26 department Business Continuity Plans that Fire and Emergency Services - Newfoundland and Labrador monitors, four have not been updated according to the timeline set in Fire and Emergency Services - Newfoundland and Labrador guidance.

**Government BCP Updating**

We determined that, as at December 31, 2015, the Government BCP had not been updated since 2010, resulting in outdated department information. This results in a risk that if the Government BCP is activated, not all department services will be included.

**Finding**

13. As at December 31, 2015, the Government Business Continuity Plan had not been updated since 2010, therefore it may not contain current information from all departments.

## 3C. Effectiveness of BCPs

**Introduction**

FES-NL is required to validate the effectiveness of the Government BCP using either designed exercises or real events. The most frequently used method to validate the Government BCP is a tabletop exercise, which is a meeting to discuss a simulated emergency situation.

FES-NL is responsible for directing departments to perform test exercises on their BCPs. FES-NL supports these exercises, but the responsibility to initiate and perform them belongs to the departments. FES-NL also invites departments to participate in exercises that it performs.

**Testing and Debriefing of BCPs**

We inspected documentation of exercises performed by FES-NL on the Government BCP and performed by departments on the department BCPs. There were three exercises performed since 2012 in which there were representatives from FES-NL and the departments in attendance.

We determined that FES-NL is assessing the effectiveness of the Government BCP and is facilitating the assessment of the effectiveness of the department BCPs.

**Finding**

14. Fire and Emergency Services – Newfoundland and Labrador is assessing the effectiveness of the Government Business Continuity Plan and is facilitating the assessment of the effectiveness of the department Business Continuity Plans.

# Recommendations

1. Fire and Emergency Services - Newfoundland and Labrador should ensure that municipalities are contacted and encouraged to finalize any Municipal Emergency Management Plans that are not yet in place and to update their Municipal Emergency Management Plans in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance. Fire and Emergency Services - Newfoundland and Labrador should ensure that this contact is documented.

2. Fire and Emergency Services - Newfoundland and Labrador should ensure that all municipalities are encouraged to perform tests and debriefs on their Municipal Emergency Management Plans in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance.

3. Fire and Emergency Services - Newfoundland and Labrador should monitor and encourage that all department Business Continuity Plans are updated in accordance with Fire and Emergency Services - Newfoundland and Labrador guidance.

4. Fire and Emergency Services - Newfoundland and Labrador should ensure that the Government Business Continuity Plan is maintained in accordance with the *Emergency Services Act*.

# Fire and Emergency Services - Newfoundland and Labrador Response

1. *Fire and Emergency Services - Newfoundland and Labrador should ensure that municipalities are contacted and encouraged to finalize any Municipal Emergency Management Plans that are not yet in place and to update their Municipal Emergency Management Plans in accordance with Fire and Emergency Services – Newfoundland and Labrador guidance. Fire and Emergency Services – Newfoundland and Labrador should ensure that this contact is documented.*

***FES-NL's Response:***

*FES-NL accepts this recommendation.*

*To this end, since the end of the report scope period, the number of municipalities (as defined in the* Emergency Services Act*) that have not begun to develop a Municipal Emergency Management Plan (MEMP) has been reduced from 16 to 11. To encourage the remaining 11 municipalities to initiate a MEMP, each has been contacted by the regional FES-NL staff offering support. On April 28, 2016, the Chief Executive Officer of FES-NL wrote each of these 11 municipalities to highlight the legislative requirement to have a MEMP, describe a MEMP and its value during an emergency or disaster, and to offer basic emergency management training and directly support the development and exercising of a MEMP. A copy of the* 12 Steps to Developing an Effective Emergency Management Plan *was also included. These measures are to continue on a bi-annual basis in an effort to encourage the 11 municipalities that have not initiated a MEMP to do so. Of further note, FES-NL would like to provide an update on the number of approved Municipal Emergency Management Plans now in place. At the end of the report scope period there were 300 approved plans, currently that number is 344.*

*FES-NL will continue with current efforts and introduce new procedures to ensure that municipalities (as defined in the* Emergency Services Act*) are contacted and encouraged to update their MEMP. In January 2016, FES-NL developed written procedures on the approval and review of plans to clarify the role of the FES-NL staff. FES-NL will continue the current practice of advancing a letter to the municipality on the anniversary date of the approval of its plan to inform them that the MEMP is due for review. This procedure, and a second on the validation of MEMPs, requires staff to utilize the AMANDA database system to track the progress of MEMPs from development to approval and record all points of contact and their activities throughout.*

*FES-NL has recently initiated a business improvement process with a focus on improved work procedures and clear outcome targets related to MEMPs. Activities will include:*

- *consideration of best practice related to the review of MEMPs,*
- *work planning to set targets on the completion, validation (and associated debriefings) and updating of MEMPs, and*
- *policy review and development on engagement with municipalities to encourage annual review/updating of MEMPs and testing, debriefing and revision of MEMPs.*

*FES-NL will develop reports to monitor progress related to these targets, utilizing increased documentation in existing information systems.*

*FES-NL will also continue to encourage municipalities to complete and update MEMPs, including through such means as: presentations and information booths at municipal events such as the Annual Symposium of Municipalities Newfoundland and Labrador and Professional Municipal Administrators Annual Convention and Trade Show; recognition of Emergency Preparedness Week; community partnerships like that with the Coalition for Persons with Disabilities - Newfoundland and Labrador; and Ministerial Statements, news releases, advisories and Twitter messaging.*

2. *Fire and Emergency Services – Newfoundland and Labrador should ensure that all municipalities are encouraged to perform tests and debriefs on their Municipal Emergency Management Plans in accordance with Fire and Emergency Services – Newfoundland and Labrador guidance.*

***FES-NL's Response:***

*FES-NL accepts this recommendation.*

*FES-NL has and will continue to utilize a variety of methods to maximize getting the message to municipalities on the importance of testing, debriefing and updating MEMPs, including those outlined above.*

*The annual letter to municipalities to remind them to review/revise MEMPs will be expanded to encourage the municipality to perform an exercise to validate its MEMP and to use any relevant finding from an exercise or emergency event to update its MEMP.*

*FES-NL has recently initiated a business improvement process as described above. This will include development of templates to assist municipalities to independently conduct testing of MEMPs.*

*FES-NL will continue to utilize emergency management training courses to provide participants insight into emergency management practices and information that can be used to enhance their emergency management plans during a test, debrief and update. FES-NL offers: Basic Emergency Management, Emergency Operations Centre Management, Exercise Design and Public Information Officer offered annually at a Fire and Emergency Training School as well as periodic offerings as requested. In 2015/16 FES-NL delivered 19 courses and facilitated another 38 online courses resulting in 486 people training.*

3. *Fire and Emergency Services – Newfoundland and Labrador should monitor and encourage that all department Business Continuity Plans are updated in accordance with Fire and Emergency Services – Newfoundland and Labrador guidance.*

***FES-NL's Response:***

*FES-NL accepts this recommendation.*

*On November 25, 2015 the Chief Executive Officer of FES-NL wrote to the Deputy Ministers and Equivalents for each of the 26 departments requesting that all BCPs that were greater than one year old be updated. This correspondence included "A Schedule of Review for Business Continuity Plans" which outlines the month each department must update its BCP.*

*Subsequent to the reporting period of this Audit, the final four of the 26 departmental BCPs were updated.*

*In January 2016, FES-NL established a procedure, with associated timelines, which requires FES-NL staff to encourage all departments to review and update their BCPs annually based on the established schedule, and to monitor monthly that this is completed.*

4. *Fire and Emergency Services – Newfoundland and Labrador should ensure that the Government Business Continuity Plan is maintained in accordance with the Emergency Services Act.*

***FES-NL's Response:***

*FES-NL accepts this recommendation.*

*The Government of Newfoundland and Labrador BCP was updated in March 2016 and a schedule has been established for review and updating on an annual basis.*

# PART 3.7

# SERVICE NL

# SAFETY AND WEIGHT INSPECTIONS OF COMMERCIAL VEHICLES

# Summary


## Introduction

Service NL has approximately 411 employees and three branches: Government Service; Consumer and Commercial Affairs; and Occupational Health and Safety. The Motor Registration Division is under the Government Service Branch. The enforcement operations of the Motor Registration Division are vital to the health and safety of the public. Enforcement staff ensure the protection of public safety and infrastructure through a number of programs, including the highway enforcement and weigh scales for commercial vehicles.

An unsafe commercial vehicle results when a mechanical or driver deficiency is identified. Deficiencies can be minor where only a verbal warning may be provided to more serious issues that require a vehicle to be taken out-of-service. An overweight commercial vehicle is the result of the vehicle exceeding its maximum authorized weight. An overweight commercial vehicle would not be unsafe unless it exceeds the registered weight that the manufacturer has specified for the vehicle.

The Motor Registration Division is responsible for the enforcement of a number of acts and regulations such as the *Highway Traffic Act* and *Dangerous Goods Transportation Act*. In addition, Service NL follows the Commercial Vehicle Safety Alliance Agreement Standards.

During our audit period a total of 43 staff worked in the highway enforcement and weigh scales for commercial vehicles program; however, this program currently has 37 staff with 11 Highway Enforcement Officers who primarily conduct safety inspections and work with portable scales and 26 Weigh Scale Inspectors who work primarily in fixed weigh scale stations.

## Objectives

The objectives of our audit were to determine whether the Motor Registration Division has an effective program to identify:

- unsafe commercial vehicles and whether the required enforcement action is taken.
- overweight commercial vehicles and whether the required enforcement action is taken.

## Scope

Our audit covered the period January 1, 2014 to December 31, 2015. Our audit included all fixed and portable weigh scale stations and safety inspections in Newfoundland and Labrador and covered commercial vehicles with the exception of buses and ambulances. A commercial vehicle includes a truck, tractor or trailer or a combination thereof exceeding a registered gross vehicle mass of 4,500 kilograms.

Our audit included interviews with Motor Registration Division management and staff; documentation of systems and processes; examination of policies and procedures, reports, and other relevant documents; and analysis of Service NL data. Sample selections were non-statistical and random.

The Department of Transportation and Works and the Office of the Chief Information Officer had information or responsibilities that affected the safety and weight inspections of commercial vehicles and were contacted as part of this audit.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

## Importance to Newfoundlanders and Labradorians

Public safety is a priority of the Government of Newfoundland and Labrador. Accidents and damages to highway infrastructure caused by unsafe or overweight commercial vehicles pose risks to the public travelling on the Province's highways. The highway enforcement and weigh scales for commercial vehicles program is designed to monitor commercial vehicles to make sure they are compliant with various safety and weight standards. An effective highway enforcement and weigh scales for commercial vehicles program is important to maintain the safety of the travelling public in the Province and prevent damage to infrastructure.

## Conclusion

We concluded that the Motor Registration Division is unable to demonstrate whether it has an effective program to identify unsafe and overweight commercial vehicles and whether the required enforcement action is taken. Our audit determined that the Motor Registration Division does not utilize expected management tools for the planning, managing, monitoring, decision-making and evaluation of the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

## Findings

Our audit of the highway enforcement and weigh scales for commercial vehicles program identified findings related to the effectiveness of enforcement.

1. Commercial Vehicles are able to avoid being inspected and/or weighed as a result of the existence of alternate routes, the direction of fixed weigh scale stations, predictable hours of operation, social media sites and mobile applications.

2. While the Motor Registration Division does monitor industry cycles and patterns, uses input from law enforcement, complaints received from the public, results from fixed weigh scales and portable operations, and observations from enforcement staff, it does not conduct traffic studies to guide operations. The Motor Registration Division also prepares statistics on enforcement blitzes that are used to help guide operations.

3. The Province installed Weigh-in-Motion Systems at four locations across the island in 2010 which provide data on vehicle traffic, including weight. Despite information from these systems, the Motor Registration Division did not evaluate and use this data to adjust its highway enforcement and weigh scale operations for commercial vehicles.

4. The Province discontinued its agreement to receive regular downloads of traffic pattern and potential violation data from the Weigh-in-Motion system effective March 31, 2015. There was no assessment of the potential benefits of maintaining the regular downloads of the system. While data is still captured remotely by the system, neither the Department of Transportation and Works or the Motor Registration Division evaluate or use the information to assist in management of highways in the Province.

5. The Motor Registration Division does not consider or review data from the collision database to direct enforcement operations.

6. Despite detailed data being produced on a daily basis at each of the fixed weigh scale stations, this information is not maintained and is not used to effectively manage or adjust enforcement activity.

7. Three of 37 inspectors did not complete 32 coached Commercial Vehicle Safety Alliance Level I inspections within six months of training which is required in order to be certified.

8. Inspectors are required to complete 32 Level I Commercial Vehicle Safety Alliance inspections each year to maintain certification. Of the 37 inspectors whose training records were examined, one inspector did not complete 32 Level I Commercial Vehicle Safety Alliance inspections in 2014-15 and three inspectors did not complete 32 Level I Commercial Vehicle Safety Alliance inspections in 2013-14 to maintain certification. Three of the inspectors who should have been de-certified, coached newly trained inspectors.

9. The Motor Registration Division was not able to confirm that inspectors completed the minimum 32 Commercial Vehicle Safety Alliance Level I inspections due to incomplete and inaccurate information in the systems, which record CVSA inspections, and problems obtaining required reports. Failure to confirm the number of inspections performed by inspectors has resulted in inspectors completing inspections when they should have been de-certified.

10. The Motor Registration Division is not confirming that inspectors are completing minimum in-service/refresher training annually.

11. The Motor Registration Division expects Transportation of Dangerous Goods training to be done on a five-year rotation. Of the 38 inspectors conducting these inspections, 17 had completed the training more than five years ago and two have never completed the required training. These 19 inspectors were still completing Transportation of Dangerous Goods inspections.

12. The primary information systems used to document the results of inspections, the AMANDA and the Motor Registration Division systems, do not contain complete and accurate information about inspections. The Motor Registration Division cannot rely on reports generated from these systems.

13. Receiving the ability to generate reports in the AMANDA system is not timely. Not being able to obtain information in a timely manner limits the Motor Registration Division's ability to monitor the highway enforcement and weigh scales for commercial vehicles program and make necessary decisions.

14. The Motor Registration Division system has accurate and complete information on special permits.

15. Defect warning tickets are not entered in the Motor Registration Division system in a timely manner and related reports cannot be generated or printed in a timely manner.

16. The Motor Registration Division does not have an up-to-date, comprehensive and accessible policies and procedures manual for safety and weight inspections and enforcement of commercial vehicles which may result in inconsistencies in inspections and enforcement.

17. Enforcement activity is captured in various systems or documents. Verbal warnings are not consolidated in one place; out-of-service information is consolidated into the carrier profile but may not be complete or accurate; and defect warning tickets are not up-to-date in the Motor Registration Division system. Therefore, it is difficult to evaluate whether the required enforcement action was taken.

18. The Department of Transportation and Works does not have a documented capital asset management plan for weigh scale equipment. A capital asset management plan could effectively evaluate ongoing capital infrastructure needs and overall maintenance requirements.

19. Service NL and the Department of Transportation and Works do not have a system in place to track the maintenance of the fixed weigh scale equipment. There is no policy or life cycle management program in place to conduct an analysis of the need to renovate or replace existing equipment.

20. Service NL is responsible for the operations of the fixed weigh scales in the Province. The Department of Transportation and Works is responsible for maintenance of these facilities. The urgency assigned to maintenance by Transportation and Works is dependent on their priorities and resources. This could result in delays in required repairs and potential temporary closure of fixed weigh scales.

21. The Motor Registration Division does not have formal goals and objectives, lacks necessary reports and therefore cannot assess and report on the attainment of its goals and objectives or effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

22. The Motor Registration Division does not have an established process to evaluate the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

## Recommendations

1. Service NL should monitor violation statistics, collision information, and other enforcement data and use this information to direct enforcement operations.

2. Service NL should confirm inspectors receive required training prior to conducting inspections and that annual and other training recertification requirements are met.

3. Service NL, in conjunction with the Office of the Chief Information Officer, should determine the cause of the problems identified with the information systems and resolve the issues identified.

4. Service NL should develop a policies and procedures manual for the safety and weight inspections and enforcement of commercial vehicles.

5. Service NL, in conjunction with Transportation and Works, should ensure that it utilizes a life cycle management plan to ensure complete and accurate systems are in place to facilitate the Department's ability to effectively monitor and maintain Provincial weigh scales.

6. Service NL should establish a process to evaluate the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

## Importance of implementing these recommendations

Implementing these recommendations will maintain or enhance public safety by verifying commercial vehicle compliance with safety and weight standards. The recommendations will also prevent premature deterioration and associated maintenance costs of Provincial roadways.

# Objectives and Scope

## Objectives

The objectives of our audit were to determine whether the Motor Registration Division (the Division) has an effective program to identify:

- unsafe commercial vehicles and whether the required enforcement action is taken.

- overweight commercial vehicles and whether the required enforcement action is taken.

Criteria were developed specifically for this audit based upon relevant legislation, departmental processes, industry standards, our related work, examinations of reports from other legislative audit offices and consultations with Division management.

## Scope

Our audit covered the period January 1, 2014 to December 31, 2015.

Our audit included all fixed and portable weigh scale stations and safety inspections in Newfoundland and Labrador and covered commercial vehicles with the exception of buses and ambulances. A commercial vehicle includes a truck, tractor or trailer or a combination thereof exceeding a registered gross vehicle mass of 4,500 kilograms.

Our audit included interviews with Division management and staff; documentation of systems and processes; examination of policies and procedures, reports, and other relevant documents; and analysis of Service NL data. Sample selections were non-statistical and random.

The Department of Transportation and Works (T&W) and the Office of the Chief Information Officer (OCIO) have information and responsibilities that affect the safety and weight inspections of commercial vehicles and were contacted as part of the audit.

Our audit was performed in accordance with standards for assurance engagements, encompassing value-for-money, established by the Chartered Professional Accountants of Canada and under the authority of the *Auditor General Act*.

We substantially completed our audit in April 2016.

# Background

Service NL has approximately 411 employees and three branches: Government Service; Consumer and Commercial Affairs; and Occupational Health and Safety. The Division is under the Government Service Branch. The enforcement operations of the Division are vital to the health and safety of the public. Enforcement staff ensure the protection of public safety and infrastructure through a number of programs, including the highway enforcement and weigh scales for commercial vehicles (the Program).

An unsafe commercial vehicle results when a mechanical or driver deficiency is identified. Deficiencies can be minor where only a verbal warning may be provided to more serious issues that require a vehicle to be taken out-of-service. An overweight commercial vehicle is the result of the vehicle exceeding its maximum authorized weight. An overweight commercial vehicle would not be unsafe unless it exceeds the registered weight that the manufacturer has specified for the vehicle.

The Division is responsible for the enforcement of a number of acts and regulations such as the *Highway Traffic Act* and *Dangerous Goods Transportation Act*. In addition, Service NL follows the Commercial Vehicle Safety Alliance Agreement Standards.

During our audit period, a total of 43 staff worked in the Program; however, the Program currently has 37 staff:

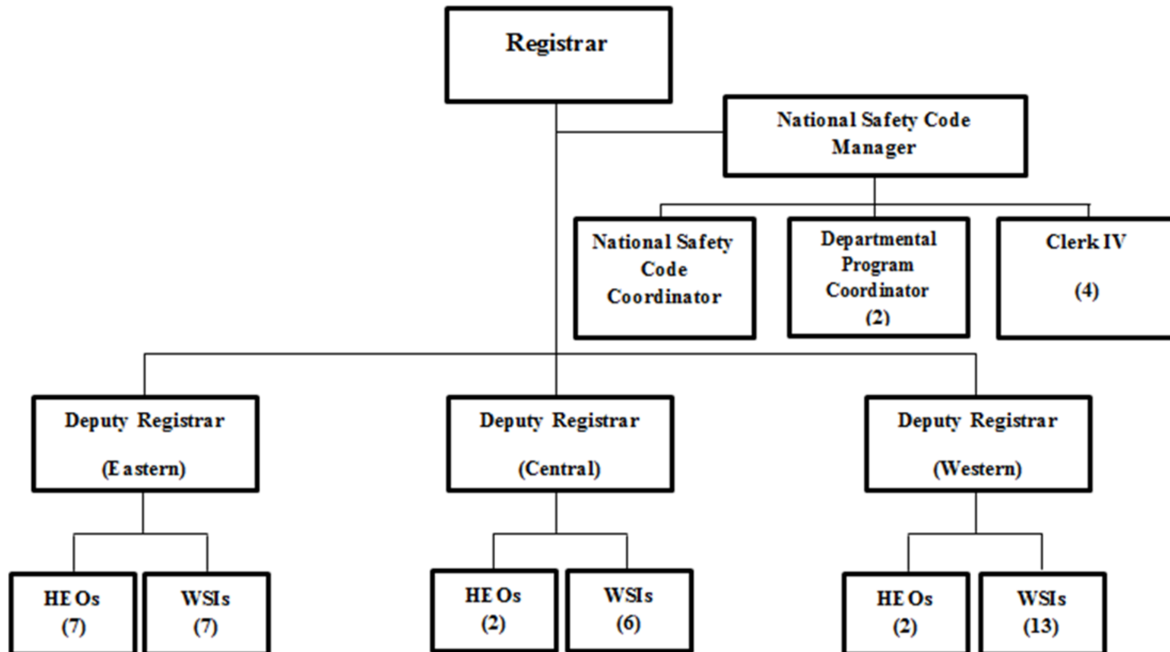
- 11 Highway Enforcement Officers (HEO) who primarily conduct safety inspections and work with portable scales, and;

- 26 Weigh Scale Inspectors (WSI) who work primarily in fixed weigh scale stations.

Program staff are also supported by other Division staff, in particular staff responsible for the National Safety Code.

**Chart 1**

**Service NL**
**Motor Registration Division**
**Organizational Chart**
**December 31, 2015**




Source: Prepared by the Office of the Auditor General of Newfoundland and Labrador (OAG) based upon information obtained from the Division.

Table 1 provides the location, direction and planned hours of operation for the six fixed weigh scale stations in Newfoundland and Labrador.

**Table 1**

**Service NL**
**Motor Registration Division**
**Fixed Weigh Scales**
**January 1, 2014 - December 31, 2015**

| Location | Direction | Planned Hours of Operation |
|---|---|---|
| Foxtrap | West | 16 hours (Monday to Friday) |
| Goobies | West and East | 24 hours (Monday to Saturday) and 16 hours (Sunday) |
| Grand Falls-Windsor | West | 24 hours (Monday to Saturday) and 16 hours (Sunday) |
| Pynn's Brook | West and East | 24 hours (Monday to Saturday) and 16 hours (Sunday) |
| Port-Aux-Basques | West and East | 24 hours (Monday to Friday) |
| Labrador West | West and East | 16 hours (Monday to Friday) |

Source: Prepared by OAG based upon information obtained from the Division.

There are portable units whose enforcement region originates at the locations shown above, except for Port-Aux-Basques. Portable units also operate from Mount Pearl and Stephenville. Portable units normally operate from 8:00am - 4:00pm (Monday to Friday).

The planned hours of operation for fixed and portable units can be adjusted as required in response to industry activity or to conduct enforcement outside normal hours of operation (such as during an enforcement blitz).

*Commercial Vehicle Safety Alliance*

The Commercial Vehicle Safety Alliance (CVSA) is an international organization comprised of local, state, provincial, territorial and federal motor carrier safety officials and industry representatives from the United States, Canada, and Mexico. The purpose of the CVSA is to encourage and promote the operation of commercial vehicles in a manner that safeguards and protects the health and safety of the general public. The CVSA provides a basic operating environment to achieve uniform standards, compatibility, and reciprocity of inspections and motor carrier safety enhancement for its member jurisdiction. In order to perform CVSA inspections, inspectors are required to be certified under the CVSA training program. Certification involves extensive training and qualifies inspectors to carry out detailed safety examinations of commercial vehicles and their drivers.

There are multiple levels of inspections under the CVSA standards.

- Level I inspection is a full inspection of both the vehicle and driver.
- Level II inspection is a walk-around driver/vehicle inspection and can be done without physically getting under the vehicle.
- Level III inspection is a driver/credential inspection.
- Level IV is a special inspection which allows the inspector to conduct a one-time examination of a particular item.
- Level V inspection is vehicle only inspection which includes each of the vehicle inspection items without a driver present.

**Figure 1**

**Service NL**
**Motor Registration Division**
**CVSA Level I Commercial Vehicle Inspection**

Source: Picture taken by OAG when observing operations on November 25, 2015.

*Transportation of Dangerous Goods*

Transport Canada develops safety standards and regulations, provides oversight and gives expert advice on the transportation of dangerous goods to promote public safety in all modes of transport in Canada. Transportation of Dangerous Goods (TDG) inspections ensure that commercial vehicles transporting hazardous materials and dangerous goods comply with applicable legislation. Transport Canada is responsible for, and also provides, TDG training to inspectors. The TDG training provided through Transport Canada is recognized by the CVSA.

# Detailed Observations

## Safety and Weight Inspections of Commercial Vehicles

**Objectives**

To determine whether the Motor Registration Division has an effective program to identify:

- unsafe commercial vehicles and whether the required enforcement action is taken.
- overweight commercial vehicles and whether the required enforcement action is taken.

### Conclusion

We concluded that the Motor Registration Division is unable to demonstrate whether it has an effective program to identify unsafe and overweight commercial vehicles and whether the required enforcement action is taken. Our audit determined that the Motor Registration Division does not utilize expected management tools for the planning, managing, monitoring, decision-making and evaluation of the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

**Overview**

Commercial vehicles that are unsafe and/or overweight can pose risks to the driving public through damage to highway infrastructure and accidents. The Program is designed to monitor commercial vehicles for compliance with various safety and weight standards. We assessed the Division against the following criteria:

1. The Department is utilizing commercial vehicle traffic patterns and statistics to guide operations.
2. Employees receive required training based on current standards and legislation including on how to operate the equipment in use by the Department.
3. The Department has an information system that captures complete and reliable information and produces accurate, relevant reports in a timely manner to assist in managing, monitoring and decision making.
4. The Department has a comprehensive policy and procedure manual that reflects current legislation and industry standards.
5. The Department has an enforcement process in place for violations.

6. The Department has a capital asset management plan to address the maintenance, repair and replacement of critical equipment.

7. The Department has a process in place to evaluate the effectiveness of its commercial vehicle weigh program.

## 1. Commercial Vehicle Traffic Patterns and Statistics

Tracking commercial vehicle traffic patterns and statistics allows the Division to focus its enforcement activities to higher volume/risk areas and can assist the Division in determining the most effective operating hours and locations for enforcement.

*Ability to Avoid Inspections*

The ability to avoid safety and weight inspections impacts the effectiveness of the Program. Drivers of non-compliant commercial vehicles may avoid being inspected or weighed.

- It is possible to take alternate routes around the Foxtrap station.

- Not all scales weigh vehicles travelling in both directions. The Grand Falls-Windsor fixed weigh scale station only captures westbound traffic. The Foxtrap station only weighs westbound traffic.

- Mobile enforcement is normally scheduled Monday to Friday from 8am to 4pm, which allows avoidance through travel outside those hours.

- Fixed weigh scale stations normally operate during established hours with one weigh scale inspector on each shift – meaning there is only one person checking for weight violations, completing CVSA inspections, writing violations/tickets, responding to in-person inquires, and answering the phones.

    - If there is a weight violation or if a vehicle needs to be inspected, the inspector may have to turn off the lights directing vehicles to the station allowing vehicles to by-pass the station. Alternatively, the station could remain open with vehicles being weighed automatically without the inspector present. In these instances, any potentially overweight or unsafe vehicles would not be diverted for enforcement.

    - The Division does not keep records of the hours of operation for fixed scales; therefore, our audit could not evaluate the actual hours of operation versus the established hours of operation.

- Social media and mobile applications are used by commercial vehicle operators to determine if a fixed station is open or closed, the most common hours of operation, if portable scales are in operation and if HEOs are performing inspections.

*Traffic Studies*

The Division does not conduct traffic studies to guide operations but does monitor industry cycles and patterns, uses input from law enforcement, complaints received from the public, results from fixed weigh scales and portable operations, and observations from enforcement staff to guide operations. The Division also prepares statistics on enforcement blitzes that are used to help guide operations.

*Weigh-in-Motion System*

In 2010, T&W and Service NL entered into an agreement to install and operate a Weigh-in-Motion System (WIMS). WIMS is built into a roadway and provides data, such as vehicle counts, weights (axle and gross), and configuration. The WIMS was intended to aid with compliance and enforcement by allowing the Division to analyze trends in highway use. The WIMS cost taxpayers $727,500 to provide monitoring of vehicle traffic.

There are four WIMS sites located throughout Newfoundland and Labrador:

- Route 1 - Trans Canada Highway, Outer Ring Road (TCH-ORR) in St. John's (eastbound);
- Route 2 - Conception Bay South (CBS) By-pass near Manuals (westbound);
- Route 430 - Great Northern Peninsula Highway near Cormack (southbound); and
- Route 1 - Trans Canada Highway near Port-Aux-Basques (eastbound).

In addition to commercial vehicle traffic patterns, the WIMS also provides information on potential weight violations. Information captured by the WIMS includes: weight (per axle or gross), a picture of the potential violator (including the license plate), speed, date, and time. The accuracy of WIMS weight readings does not permit the readings to be used for enforcement, but the data captured can be used to assist in directing enforcement operations.

Despite information from these systems, the Division did not evaluate and use this data to adjust its highway enforcement and weigh scale operations for commercial vehicles. If information from the WIMS had been evaluated for utilization to enhance and/or direct enforcement, it could supplement the fixed and portable stations to improve proactive enforcement.

Effective March 31, 2015, T&W made the decision to discontinue the regular WIMS downloads due to lack of use and budgetary considerations. The WIMS downloads were occurring regularly Monday to Friday (and could also be done on weekends by special request) from each location to a central server. There was no evaluation of the potential benefits of the WIMS to both T&W and Service NL prior to terminating the contract. The server renewal had an annual cost of $34,975.

*Commercial Vehicle Collision Database*

Service NL, effective November 2015, is the sole owner of a collision database with the Newfoundland and Labrador Statistics Agency responsible for data entry. Prior to November 2015, Service NL was a joint owner of a collision database with T&W.

We requested a report for 2014 and 2015 calendar years on collisions involving commercial vehicles. However, Service NL could not provide such a report as reports have not been generated from the system since 2011. The Division did provide us with data from the collision database for the 2014 calendar year. As of March 2016, the data for 2015 was not yet entered.

The data for 2014 indicated that 346 commercial vehicles were involved in 335 collisions. This data included information such as: details of driver and collision location and road details, severity, collision configuration, vehicle tires, weather conditions, road classification, vehicle type, contributing factors, etc. There is considerable information at the Division's disposal. However, the Division did not consider or review this data to direct enforcement operations.

*Bidirectional Multi-Platform Scale Interface*

The Bidirectional Multi-Platform Scale Interface (BMSI) is the information system used at the fixed weigh scale stations to capture the weight of commercial vehicles as they go over the scales and generate related reports. The BMSI produces summary shift reports in real time at the end of an inspector's shift that includes: the date; inspector number; login and logout time; total truck count; violations count (if the inspector enters the information); and total weights for each axle for the shift. Service NL does not maintain copies of the summary shift reports which could be used to prepare volume and violation statistics and assist with evaluating the operations of each fixed weigh scale station.

## Findings

1. Commercial Vehicles are able to avoid being inspected and/or weighed as a result of the existence of alternate routes, the direction of fixed weigh scale stations, predictable hours of operation, social media sites and mobile applications.

2. While the Motor Registration Division does monitor industry cycles and patterns, uses input from law enforcement, complaints received from the public, results from fixed weigh scales and portable operations, and observations from enforcement staff, it does not conduct traffic studies to guide operations. The Motor Registration Division also prepares statistics on enforcement blitzes that are used to help guide operations.

3. The Province installed Weigh-in-Motion Systems at four locations across the island in 2010 which provide data on vehicle traffic, including weight. Despite information from these systems, the Motor Registration Division did not evaluate and use this data to adjust its highway enforcement and weigh scale operations for commercial vehicles.

4. The Province discontinued its agreement to receive regular downloads of traffic pattern and potential violation data from the Weigh-in-Motion system effective March 31, 2015. There was no assessment of the potential benefits of maintaining the regular downloads of the system. While data is still captured remotely by the system, neither the Department of Transportation and Works or the Motor Registration Division evaluate or use the information to assist in management of highways in the Province.

5. The Motor Registration Division does not consider or review data from the collision database to direct enforcement operations.

6. Despite detailed data being produced on a daily basis at each of the fixed weigh scale stations, this information is not maintained and is not used to effectively manage or adjust enforcement activity.

## 2. Training/Certification

**Introduction**

Well-defined and documented training requirements and programs ensure that inspectors possess the necessary skills and experience to conduct safety and weight inspections. We examined legislation and regulations, examined required training (including the curriculum), training schedules, the number of inspections completed by each inspector and observed a training session. We also enquired with the Division and Transport Canada to obtain information regarding the training received by inspectors.

**Required Training - Commercial Vehicle Safety Inspections**

*CVSA Training and Certification*

We examined CVSA training received by 37 inspectors and found:

- All inspectors received CVSA Level I training;

- All inspectors completed CVSA training prior to completing a Level I inspection; and

- Three of 37 inspectors did not complete the required 32 coached CVSA Level I inspections within six months of receiving CVSA training. Therefore, these three inspectors should have either retaken the exam and/or taken the course over again.

*Maintaining CVSA Certification*

CVSA Policy requires inspectors to complete a minimum of 32 Level I CVSA inspections each year to maintain certification. If an inspector does not perform the minimum number of inspections within the previous 12-month period, the inspector shall be de-certified. Our testing of the 37 inspectors indicated that:

- one inspector did not complete 32 Level I CVSA inspections in 2014-15,
- three inspectors did not complete 32 Level I CVSA inspections in 2013-14, and
  - three of these inspectors did not complete 32 Level I CVSA inspections in either year.
- three of the these four inspectors, who should have been de-certified, coached newly trained inspectors

CVSA Policy requires that member jurisdictions ensure that inspectors have conducted the minimum 32 CVSA inspections. The Division was not able to confirm that inspectors completed the minimum 32 CVSA inspections due to incomplete and inaccurate information in the systems, which record CVSA inspections, and problems obtaining required reports. Failure to confirm the number of inspections performed by inspectors resulted in inspectors completing inspections when they should have been de-certified.

CVSA Policy requires that inspectors shall attend minimum in-service/refresher training annually. The Division is not confirming that inspectors are completing minimum in-service/refresher training annually.

*Transportation of Dangerous Goods Inspections Training*

There is no expiry term for TDG training. Transport Canada is responsible for, and also provides, TDG training to inspectors. Provinces are responsible for determining their own operational requirements regarding ongoing training. While there is no formal documented Division policy, TDG training is expected to be done on a five-year rotation. Of the 38 inspectors conducting TDG inspections:

- 17 had completed the TDG training more than five years ago, and
- two have never completed the required training.

These 19 inspectors were still completing TDG inspections.

**Required Training - Commercial Vehicle Weight Inspections**

Inspectors receive on the job training for operation of the fixed or portable weigh scales.

**Findings**

7. Three of 37 inspectors did not complete 32 coached Commercial Vehicle Safety Alliance Level I inspections within six months of training which is required in order to be certified.

8. Inspectors are required to complete 32 Level I Commercial Vehicle Safety Alliance inspections each year to maintain certification. Of the 37 inspectors whose training records were examined, one inspector did not complete 32 Level I Commercial Vehicle Safety Alliance inspections in 2014-15 and three inspectors did not complete 32 Level I Commercial Vehicle Safety Alliance inspections in 2013-14 to maintain certification. Three of the inspectors who should have been de-certified, coached newly trained inspectors.

9. The Motor Registration Division was not able to confirm that inspectors completed the minimum 32 Commercial Vehicle Safety Alliance Level I inspections due to incomplete and inaccurate information in the systems, which record CVSA inspections, and problems obtaining required reports. Failure to confirm the number of inspections performed by inspectors has resulted in inspectors completing inspections when they should have been de-certified.

10. The Motor Registration Division is not confirming that inspectors are completing minimum in-service/refresher training annually.

11. The Motor Registration Division expects Transportation of Dangerous Goods training to be done on a five-year rotation. Of the 38 inspectors conducting these inspections, 17 had completed the training more than five years ago and two have never completed the required training. These 19 inspectors were still completing Transportation of Dangerous Goods inspections.

## 3. Information Systems

**Introduction**

A well-designed information system(s) with complete and accurate information would assist staff in managing the Program. We examined the AMANDA and Motor Registration Division systems and interviewed inspectors and management to obtain information on the data entry procedures for both systems. Both systems are maintained by the OCIO.

Motor Registration Division System (MRD System)

The MRD system is an older mainframe system that allows staff to inquire into and update driver and vehicle information, print permits, and view and update motor carrier profiles. Inspectors' access is limited to activities such as looking up driver and vehicle information and issuing permits.

AMANDA System

The AMANDA system is used to document the results of inspections and is intended to produce reports, including reports for court purposes. Inspectors use a mobile version of AMANDA to document the results of their inspections. Managers are able to review and generate reports from the information uploaded by inspectors from the mobile version to the AMANDA system. The AMANDA system is designed to interface with the MRD system to upload inspection details and download vehicle information.

**Completeness and Accuracy of Information**

*Commercial Vehicle Safety Inspections*

The AMANDA system contains inaccurate and incomplete information on unsafe commercial vehicles:

- Mobile AMANDA is not correctly synchronizing vehicle data from the MRD system to access information such as the vehicle and driver history.

- AMANDA is missing 232 CVSA inspection records because of an undetected software problem impacting the uploading of data from the mobile AMANDA to AMANDA.

- The system is unable to correctly monitor compliance with CVSA inspector certification requirements. There were 541 errors in the generated reports.

- If mobile AMANDA is not accessible, inspectors manually record the results of CVSA inspections on paper. These CVSA inspections cannot subsequently be recorded in AMANDA and can only be recorded in the MRD system. These manually recorded CVSA inspections are not input into the MRD system in a timely manner.

- Receiving the ability from OCIO to generate reports from AMANDA can be a long process which is completed on a priority basis established by OCIO. A report on CVSA inspections by inspectors was requested in 2012 and 2014 by the Carrier Compliance Coordinator; however, the Division did not get that report until we requested the report for our audit.

- There is no documented policy requiring inspectors to upload CVSA inspection reports in a timely manner. As a result, AMANDA reports will not be complete if the results of these inspections are not uploaded.

The MRD system contains inaccurate and incomplete information on unsafe commercial vehicles:

- 190 inspections, dating back to 2014, were rejected by the MRD system when uploading from AMANDA. These rejected items have not been corrected.

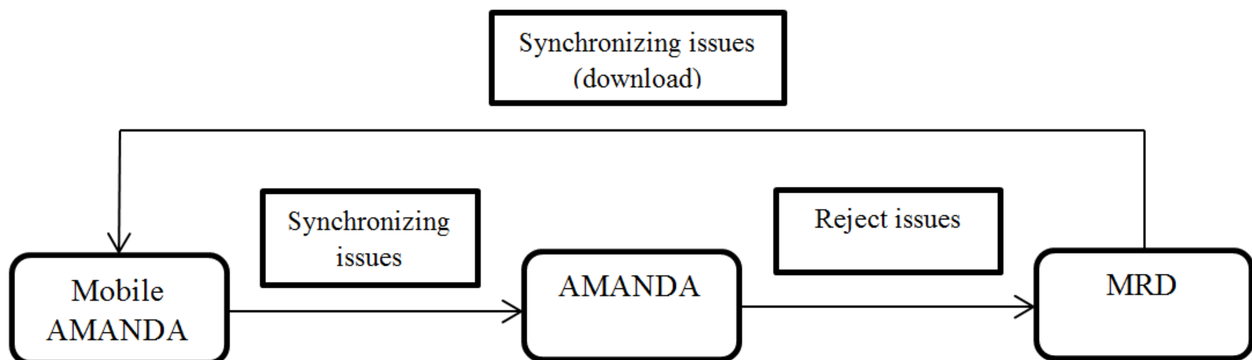
- CVSA inspections that are recorded on paper rather than mobile AMANDA are not entered into AMANDA (as noted above) but instead are directly entered into the MRD system. These paper copies are not inputted into the MRD system in a timely manner resulting in inaccurate reports.

- Defect warning tickets issued are manually entered into the MRD system; however, they are not entered in a timely manner. There are three types of defect warning tickets: inspection, warning report and out-of-service notice.

- There is no documented policy requiring inspectors to upload CVSA inspection reports in a timely manner. As a result, MRD system reports will not be complete if the results of these inspections are not uploaded.

**Chart 2**

**Service NL**
**Motor Registration Division**
**Information Systems Flowchart**
**January 1, 2014 - December 31, 2015**




Source: Prepared by OAG based upon information obtained from the Division.

**Findings**

12. The primary information systems used to document the results of inspections, the AMANDA and the Motor Registration Division systems, do not contain complete and accurate information about inspections. The Motor Registration Division cannot rely on reports generated from these systems.

13. Receiving the ability to generate reports in the AMANDA system is not timely. Not being able to obtain information in a timely manner limits the Motor Registration Division's ability to monitor the highway enforcement and weigh scales for commercial vehicles program and make necessary decisions.

*Commercial Vehicle Weight Inspections*

The MRD system captures special permits. Special permits are required for any person who operates or moves a vehicle or combination of vehicles, object, structure or load that exceeds the weight or dimensions specified in the regulations. A special permit can only be issued once validated in the system; therefore, as soon as a special permit needs to be issued, it is generated from the system and is up-to-date.

Defect warning tickets issued for overweight commercial vehicles are manually entered in the MRD system. However, these tickets are not entered in the MRD system in a timely manner. Managers have to request the OCIO to generate and print reports on defect warning tickets and special permits.

**Findings**

14. The Motor Registration Division system has accurate and complete information on special permits.

15. Defect warning tickets are not entered in the Motor Registration Division system in a timely manner and related reports cannot be generated or printed in a timely manner.

## 4. Policies and Procedures

**Introduction**

Well-defined and documented guidelines and standards would assist inspectors in the inspection and enforcement process. We examined applicable legislation, CVSA policies, internal communications and interviewed Department officials.

Program staff are responsible for knowledge of applicable legislation, inspection processes and enforcement activities relating to unsafe and overweight commercial vehicles. Inspectors are responsible for safety and weight inspections and enforcement activities for commercial vehicles.

**Policies and Procedures Manual**

The Division does not have an up-to-date, comprehensive and accessible policies and procedures manual. The Division communicates to the inspectors through memos and emails which are not maintained in a central repository. These memos address specific issues as they occur. CVSA provides a comprehensive policies and procedures manual for safety inspections of commercial vehicles. The *Highway Traffic Act* provides specific guidance related to certain enforcement activity. An up-to-date, comprehensive and accessible policies and procedures manual that reflects current legislation and industry standards would provide guidance to staff and help ensure inspectors carry out their duties related to safety and weight inspections and enforcement of commercial vehicles in a consistent manner.

### Finding

16. The Motor Registration Division does not have an up-to-date, comprehensive and accessible policies and procedures manual for safety and weight inspections and enforcement of commercial vehicles which may result in inconsistencies in inspections and enforcement.

## 5. Enforcement

**Introduction**

Inspectors have a number of enforcement options available to deal with non-compliant commercial vehicles:

- Verbal warning.

- Defect warning ticket.
  - A defect warning ticket is not submitted to the traffic court and there is no fine.

- Vehicle taken out-of-service
  - Unsafe commercial vehicle - the vehicle is parked until all critical defects are repaired.
  - Overweight commercial vehicle - the vehicle is left at the station until the load is adjusted and brought into compliance.

- Summary Offence Ticket (SOT)
  - SOTs are issued pursuant to the *Highway Traffic Act* and have a fine attached.

- Special permit for an overweight commercial vehicle
  - Issued, for a fee, if the vehicle is over the registered weight but under the manufacturer's weight limit.

### Enforcement Activity Information

Capturing and utilizing information on enforcement activities allows the Division to focus its enforcement activities relating to violation type, vehicle, company, location, etc. Enforcement activity information is currently captured in the following ways:

- Verbal warnings may be noted in the inspector's daily patrol sheets (dailies) and in the comments section of CVSA inspection reports. The Division does not consolidate verbal warnings in order to be able to track offences by vehicle, company or driver.

- A report can be generated for defect warning tickets by the MRD system; however, this data is not up-to-date.

- Out-of-service information may be noted in dailies, in the comments section of CVSA inspection reports and on defect warning tickets. The Division consolidates out-of-service information into the carrier profile (measurement of a carrier's on road performance). However, the carrier profile may not be complete or accurate due to the issues with information systems previously mentioned.

- SOTs are not captured at the Division but are sent to Traffic Court. Therefore, the Division must request reports generated by the Traffic Court.

- For overweight commercial vehicles, a special permit can only be generated from the MRD system; therefore, special permit information is always up-to-date.

### Finding

17. Enforcement activity is captured in various systems or documents. Verbal warnings are not consolidated in one place; out-of-service information is consolidated into the carrier profile but may not be complete or accurate; and defect warning tickets are not up-to-date in the Motor Registration Division system. Therefore, it is difficult to evaluate whether the required enforcement action was taken.

## 6. Capital Asset Management Plan

### Introduction

A capital asset management plan is a process used to determine and evaluate capital infrastructure needs and maintenance requirements. A well-defined and documented capital asset management plan ensures that critical equipment requirements are identified and that equipment is properly maintained. T&W is responsible for major capital infrastructure acquisitions and maintenance, such as the fixed weigh scales; whereas, Service NL is responsible for more minor and portable items, such as the portable weigh scales.

**Equipment Maintenance**

Well-defined and documented guidelines and standards should be in place to assist staff in the maintenance of both fixed and portable weigh scales. However, there is no specific manufacturer recommended standards for the maintenance of the fixed or portable weigh scales. Without such guidance, it is difficult to ensure that measures are in place to ensure routine preventative maintenance is conducted.

*Fixed Scales*

The fixed scales are certified (calibrated) and checked annually. T&W conducts repairs as required and assesses malfunctioning equipment on an on-going basis. T&W does not track the dates that weigh scales were out-of-service.

There is no policy to assign a repair priority for malfunctioning equipment. T&W completes repairs depending on the nature of the repair priority, in relation to that of all other assets T&W is responsible for. Waiting for repairs can potentially cause a fixed weigh scale station to be closed for extended periods of time. For example, an electrical problem with the lighting system at the Grand Falls-Windsor fixed weigh scale station caused the station to be closed for four weeks ending in late February 2014 and the replacement of the scale pins caused the station to be closed for six weeks ending in January 2015.

T&W will periodically assess fixed weigh scale stations and determine the need for a major repair, refurbishment or replacement. Service NL would be responsible for informing T&W of any identified issues with existing facilities (e.g. condition, improvements, location etc.) so that this information can be included in any assessments conducted.

**Figure 2**

**Department of Transportation and Works**
**Foxtrap Fixed Weigh Station**
**August 2013**

Source: Picture obtained from *GoogleMaps*

*Portable Scales*

Portable scales are used by inspectors to weigh commercial vehicles at any location. A visual inspection of the scales takes place after every use and they are calibrated annually. Service NL implemented a process to track maintenance, calibration and repair of portable scales in August 2015. The Division also has spare units available for use to replace malfunctioning portable units or units that have reached the end of their service life.

**Figure 3**

**Service NL**
**Motor Registration Division**
**Weighing a Commercial Vehicle with Portable Scales**
**November 25, 2015**

Source: Picture taken by OAG when observing operations on November 25, 2015.

## Findings

18. The Department of Transportation and Works does not have a documented capital asset management plan for weigh scale equipment. A capital asset management plan could effectively evaluate ongoing capital infrastructure needs and overall maintenance requirements.

19. Service NL and the Department of Transportation and Works do not have a system in place to track the maintenance of the fixed weigh scale equipment. There is no policy or life cycle management program in place to conduct an analysis of the need to renovate or replace existing equipment.

20. Service NL is responsible for the operations of the fixed weigh scales in the Province. The Department of Transportation and Works is responsible for maintenance of these facilities. The urgency assigned to maintenance by Transportation and Works is dependent on their priorities and resources. This could result in delays in required repairs and potential temporary closure of fixed weigh scales.

## 7. Evaluation of the Program

### Introduction

A well-defined, documented and regular evaluation process is important so that the Division can monitor and evaluate the effectiveness of the Program by comparing the actual performance against the Division's objectives and other criteria or benchmarks. We used the following factors to determine if the Division evaluates the Program:

- Attainment of established goals and/or objectives; and
- Established evaluation process.

### Established Goals and Objectives

Service NL's strategic plan for 2014-17 establishes goals for the Department. The Division does plan and establish goals for enforcement operations, but as for any tactical operation the plan is fluid as it requires shifting resources.

We examined the strategic plan, documentation provided by the Division, and held discussions with the Registrar pertaining to the goals and objectives. For our audit period, the Division had informal goals that were broad in nature and included but were not limited to:

- mobile enforcement operations beyond 8am to 4pm Monday to Friday with a minimum of one weekend per month;
- minimum of one CVSA blitz per month, per region for unsafe commercial vehicles;
- one Province Wide CVSA blitz per quarter for unsafe commercial vehicles; and
- a fixed scale site open 24 hours per day for overweight commercial vehicles.

*Mobile Enforcement*

The Division uses a targeted approach for mobile enforcement. The established goals for mobile operations/portable scales include the frequency of visits to an area and the number of vehicles to be inspected/weighed. The intent is not to frequently patrol areas that have little to no commercial activity. For example, goals for the Eastern Region Mobile Operation for 2013-14 included weighing/inspecting four vehicles per day per mobile/portable unit for areas with higher traffic levels, such as St. John's/Mount Pearl and Clarenville/Goobies.

The Division has informal goals for the Program and is using a targeted approach to enhance its enforcement.

**Attainment of Established Goals and Objectives**

Whether goals are achieved is influenced by several factors and depending on the goal, it can be measured through various means, such as scheduling for the number of days an inspection/weigh station is operational.

Reviews of the Program by Division management or independent professionals are important methods to determine the effectiveness of the Program. Internal reviews help management to identify deficiencies in operations while external reviews provide an unbiased opinion on the performance of the Program. Only one external review of the Program occurred which was in 2010. There was an enforcement plan presentation to Service NL executive by the Registrar in 2013.

*Commercial Vehicle Safety Inspections*

We interviewed the Registrar about the approach used to measure performance against the informal goals. The Program measures success through compliance. After every inspection blitz, there is a report on the number of inspections conducted and the type of out-of-service issues found. This is sometimes reported nationally, provincially or informally, but it is not used to measure program effectiveness, but rather to direct operations. As an example, if one in every four vehicles inspected have been taken out of service then it will impact when and how long the next blitz will be.

*Commercial Vehicle Weight Inspections*

We interviewed the Registrar about the approach used to measure performance against the informal goals. The Division does not keep records of the hours of operation for fixed scales; therefore, the goal of a fixed scale site open 24 hours a day cannot be determined. Attendance sheets were not always complete for the mobile operations as well. There is no easily generated report that reports on the goals for portable scales, i.e. frequency to visit an area and the number of vehicles to be weighed. We requested a report for the number of vehicles weighed and found there is no information captured for the portable scales in Foxtrap, Goobies, Pynn's Brook and Labrador in both 2014 and 2015 calendar years. The Registrar explained that there is data available for portable units that is not reflected in the report. The information is recorded in the HEOs' dailies and can be consolidated but would have to be manually consolidated.

There has not been an evaluation of the location of fixed weigh scale stations to determine if they are in optimal locations and properly designed to inspect commercial vehicles.

## Finding

21. The Motor Registration Division does not have formal goals and objectives, lacks necessary reports and therefore cannot assess and report on the attainment of its goals and objectives or effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

**Established Evaluation Process**

A process should be in place to evaluate and report on the effectiveness of the Program through the planning, operating, monitoring and reporting stages. We requested reports and any relevant information that management uses to monitor the effectiveness of the Program.

The Division does collect information but as noted previously, there are issues with the completeness and accuracy of this information. The Division undertakes some evaluation but does not thoroughly evaluate the Program and report results.

Without an established evaluation process, the Division may not able to identify deficiencies in operations so that they can be addressed and improve the effectiveness of the Program.

**Finding**

22. The Motor Registration Division does not have an established process to evaluate the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

# Recommendations

1. Service NL should monitor violation statistics, collision information, and other enforcement data and use this information to direct enforcement operations.

2. Service NL should confirm inspectors receive required training prior to conducting inspections and that annual and other training recertification requirements are met.

3. Service NL, in conjunction with the Office of the Chief Information Officer, should determine the cause of the problems identified with the information systems and resolve the issues identified.

4. Service NL should develop a policies and procedures manual for the safety and weight inspections and enforcement of commercial vehicles.

5. Service NL, in conjunction with Transportation and Works, should ensure that it utilizes a life cycle management plan to ensure complete and accurate systems are in place to facilitate the Department's ability to effectively monitor and maintain Provincial weigh scales.

6. Service NL should establish a process to evaluate the effectiveness of the highway enforcement and weigh scales for commercial vehicles program.

# Service NL's Response

***Recommendation #1***

***Service NL should monitor commercial vehicle traffic patterns, violation statistics, collision information and other enforcement data and use this information to direct enforcement operations.***

***Service NL Response:*** *Service NL accepts the recommendation and will review all available data, considering the relative timeliness and reliability of various sources of information.*

*Service NL monitors commercial traffic patterns and periodically conducts analysis of traffic flow throughout the year, from data provided through the Weigh Scales, to assist in planning scale operations. Service NL also guides its operations based on input from other sources such as:*

1. *industry cycles and patterns of movement (for example, associated with major projects and industrial development such as Long Harbour, Bull Arm and the various Nalcor sites);*
2. *input from law enforcement officials;*
3. *Complaints from the public; and*
4. *Observations by Service NL enforcement staff.*

*In addition, shifts for portable units and fixed scales, as well as highway enforcement patrols, are adjusted to enhance enforcement in response to industry activity and to measure and confirm the level of commercial traffic activity on any given day. Service NL will consider use of all other data sources which provide accurate and reliable data.*

***Recommendation #2***

***Service NL should confirm inspectors receive required training prior to conducting inspections and that annual and other training recertification requirements are met.***

***Service NL Response:*** *Service NL accepts the recommendation and has taken steps to improve tracking of training and certification of employees. Service NL is confident in the skills and expertise of its employees. While the tracking of training is important, Service NL notes that the position descriptions for Highway Enforcement Inspectors requires the incumbent either be a certified Journeyperson Mechanic or have equivalent experience or certification in heavy equipment or vehicle maintenance or repair. These qualifications and skills permit inspectors to conduct vehicle inspections properly without any additional certification. Commercial Vehicle Safety Alliance (CVSA) training is provided in addition to these qualifications to ensure consistency with national standards across the country.*

*While on-the-job training has been determined to be the most efficient and effective method for learning weigh scales operations, Service NL offers formal training for inspectors on a number of aspects of enforcement such as CVSA inspections, Transportation of Dangerous Goods (TDG), conduct of investigations and court procedures. Service NL plans to formalize the delivery and confirmation of annual refresher CVSA refresher training, effective immediately. It is also noted that, as of April 1, 2016, Service NL implemented a new classification structure for its enforcement program, consolidating the former two classifications of Weigh Scale Inspector and Highway Enforcement Officer into a single classification (Highway Enforcement Officer I) and created four regional enforcement "lead hand" supervisory positions (Highway Enforcement Officer II). Service NL will use these latter positions to conduct the annual CVSA refresher training.*

***Recommendation #3***

***Service NL, in conjunction with the Office of the Chief Information Officer (OCIO), should determine the cause of the problems within the information system and resolve the issues identified.***

***Service NL Response:*** *Service NL accepts the recommendation. Service NL receives ongoing information technology support from the OCIO. The technical issues highlighted in this report were already known to both entities, and Service NL has been working with the OCIO to resolve them. Some of the issues highlighted in the report, such as the software problem affecting the uploading of data from the mobile AMANDA application to the AMANDA database, and correction of technical issues surrounding tracking of inspections and duplication of reports, have already been resolved.*

***Recommendation #4***

***Service NL should develop a policies and procedures manual that clearly defines the inspection and enforcement process for unsafe and overweight commercial vehicles.***

*Service NL Response: Service NL accepts the recommendation. In June 2016, Service NL developed and issued an Enforcement Manual, to provide guidance to enforcement staff related to activities and issues.*

## Office of the Chief Information Officer's Response

***Recommendation #3***

***Service NL, in conjunction with the Office of the Chief Information Officer, should determine the cause of the problems within the information system and resolve the issues identified.***

*The Office of the Chief Information Officer will continue to work with Service NL on the identified concerns.*

## Department of Transportation and Works' Response

***Recommendation #5***

***Service NL, in conjunction with Transportation and Works, should ensure that it utilizes a life cycle management plan to ensure complete and accurate systems are in place to facilitate the Department's ability to effectively monitor and maintain Provincial weigh scales.***

*Transportation and Works acknowledges that it does not have a documented life cycle management plan for weigh scale equipment; however, Transportation and Works and Service NL will work to develop a plan over the course of the current fiscal year.*