AUDITOR GENERAL
of Newfoundland and Labrador

Report to the House of Assembly on Reviews of Departments and Crown Agencies

June 2015

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 a highly valued legislative audit office recognized for assisting Members of the House of Assembly in holding Government accountable for the prudent use and management of public resources.

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AUDITOR GENERAL
of Newfoundland and Labrador

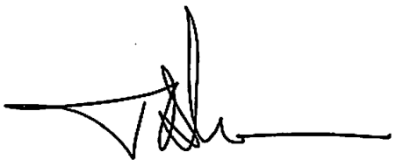
June 2015

The Honourable Wade Verge, 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 Reviews of Departments and Crown Agencies for 2015.

Respectfully submitted,



TERRY PADDON, CPA, CA
Auditor General

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CHAPTER 1

COMMENTS OF THE AUDITOR GENERAL

This is my fourth 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, 2014.

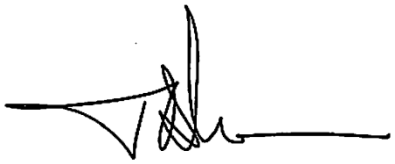
The *Auditor General Act* requires that I report, at least annually, to the House of Assembly on the work of the Office. This report, and the report on the Consolidated Summary Financial Statement of the Province, fulfill the requirements of the *Auditor General Act*.

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 10 different programs and crown agencies:

- Labour Market Development Agreement
- Financial Assistance to Business
- Teacher Professional Development
- Office of the Chief Information Officer
- Newfoundland and Labrador Prescription Drug Program
- Nutrition in Long-term Care Facilities
- Personal Care Home Regulation
- Municipal Infrastructure
- Pension Plan Regulation
- Use of External Consultants

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 June 2015 Report on Reviews of Departments and Crown Agencies.

The following is the staff of the Office of the Auditor General as of May 31, 2015:

Nicole Abbott, CPA, CA
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Paul Burggraaf, CAPM
Greg Butler
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Tony Wiseman

CHAPTER 3

REVIEWS OF DEPARTMENTS AND CROWN AGENCIES

PART 3.1

DEPARTMENT OF ADVANCED EDUCATION AND SKILLS

LABOUR MARKET DEVELOPMENT AGREEMENT

Summary

Introduction

The Department of Advanced Education and Skills (AES) has a mandate to ensure the Province has highly educated graduates and skilled workers available for the economy. AES has four lines of business:

- employment support and career services;
- labour market development and immigration;
- post-secondary education and learning; and
- policy development, review and input on cross-government initiatives.

From 1996 until 2009, Employment Benefits and Support Measures (EBSMs) were delivered by Human Resources Development Canada (HRDC) as part of the *Employment Insurance Act* (*EI Act*). On September 4, 2008, HRDC devolved its labour market development responsibilities to the Province with the signing of the Labour Market Development Agreement (LMDA). The LMDA came into effect on November 2, 2009.

EBSMs are part of the employment insurance system and assist individuals to return to work and reduce their dependency on Employment Insurance (EI) and provincial income assistance.

Employment Benefits are designed to assist individual clients to develop and implement a plan to return-to-work. The focus is on providing assistance with skills development, wage subsidies, job creation and self-employment. Employment Benefits are available to eligible participants, including active and former EI claimants.

Support Measures are designed to facilitate community-based delivery of employment services and to assist community level partners to enhance employment prospects in their area and are available to all unemployed individuals.

Integrated Case Management System Project

As a result of LMDA devolution, the Province required a software solution to assist in the delivery of EBSMs. To assist with the costs of designing and implementing an Integrated Case Management System (ICMS), the Province signed a Supplementary Agreement with the Government of Canada (Canada) on August 5, 2010. This agreement covered eligible system development costs between April 1, 2010 and March 31, 2012 to a maximum of $8 million.

On September 18, 2009, the Office of the Chief Information Officer (OCIO) issued a request for proposal (RFP) to acquire a Commercial-Off-The-Shelf (COTS) software solution for the purposes of meeting the ICMS business requirements of the LMDA. Three bids were received and on August 5, 2010, a Procurement Agreement was signed with the successful bidder (Vendor) and work on the ICMS Project commenced shortly thereafter.

Objectives

The objectives of our review were:

1. To determine whether the Department of Advanced Education and Skills (AES) is managing Part II - Employment Benefits of the Labour Market Development Agreement (LMDA) in accordance with program policies;

2. To determine whether:

    a) the request for proposal (RFP) and contract awards related to the Integrated Case Management System Project (ICMS) were conducted in accordance with the provisions of the *Public Tender Act* and the *Public Tender Regulations, 1998*, and

    b) the bids were appropriately evaluated;

3. To determine whether payment and monitoring activities related to the ICMS Project were conducted in accordance with the terms of the Procurement Agreement and certification procedures; and

4. To determine whether the decision to terminate the Procurement Agreement for the ICMS Project was appropriately evaluated.

Scope

Our review of LMDA related case file assessments covered the funding period from April 1, 2011 to December 31, 2013. We reviewed AES Policy, case files and information submitted by applicants. All samples selected during our review were determined non-statistically and judgmentally. Our review examined the following programs provided by AES through the LMDA:

1. Skills Development

2. Targeted Wage Subsidies

Our review of the ICMS Project covered the period September 2009 to August 2011. We reviewed the September 2009 issuance of the RFP, the awarding of the contract in August 2010, the work performed under the contract to the spring of 2011, and the termination of the contract in April 2011.

We completed our reviews in December 2014.

Conclusions

Objective 1

For the samples selected, we found that in some instances AES was not properly managing Part II - Employment Benefits in accordance with program policies established under the LMDA.

Objective 2

The RFP and contract award related to the ICMS Project was conducted in accordance with the provisions of the *Public Tender Act* and the *Public Tender Regulations, 1998*.

The bids received in response to the RFP related to the ICMS Project were properly evaluated. However, there was no additional evaluation undertaken to assist in identifying potential misunderstandings or errors in the original RFP or received proposals as a result of a significant disparity in costs between the proposal from the vendor and other qualified bidders.

Objective 3

Payment and monitoring activities were not conducted in accordance with either the Procurement Agreement or certification procedures.

Objective 4

The decision to terminate the Procurement Agreement was not properly evaluated.

Findings

Part II Employment Benefits

1. Since the Province assumed responsibility for delivery of benefits under the LMDA, almost $600 million has been directed to enhancing employment skills for Newfoundlanders and Labradorians in the four and a half years since 2009. The Federal Government managed the LMDA programs for the 13 year period prior to 2009.

Skills Development

2. For the files reviewed, completed Return to Work Action Plans in some instances did not clearly demonstrate that participants possessed barriers to employment.

3. For the files reviewed, AES staff were not adequately verifying the client-submitted costs and income sources for accuracy, existence, and completeness when negotiating the level of funding for monthly living and incremental costs.

4. For the files reviewed, AES did not adequately monitor the attendance of participants in funded training programs. As a result, AES may also be missing opportunities to maximize opportunities for tuition refunds.

Targeted Wage Subsidies

5. For the files reviewed, we found one instance where a Targeted Wage Subsidy was funded at an amount higher than what was provided for in the contribution agreement which lead to an overpayment of $1,258.

Integrated Case Management System Contract Award

Compliance with the Public Tender Act *and* Regulations

6. The OCIO conducted the contract award process in accordance with the *Public Tender Act* and the *Public Tender Regulations, 1998.*

Proposal Evaluation

7. The RFP Evaluation Committee did not adequately assess the risk associated with the estimated project costs from the Vendor before scoring the Financial Proposal Requirements section of their proposal even though the second bidder was 1.9 times higher than the Vendor and the third bidder was 2.4 times higher.

Integrated Case Management System Payment and Monitoring Activities

8. All Statements of Work (SOW) were approved after work had commenced. As a result, the Province diminished its ability to manage project costs and deliverables by allowing approximately 82% of the work to be completed by the Vendor before obtaining mutual agreement on the terms of the SOW.

9. The AES Project Manager and OCIO Delivery Manager did not confirm their acceptance in writing of four deliverables specified on SOW #3.

10. Three of seven deliverables specified on SOW #3 were never completed by the Vendor.

11. The AES Project Manager and OCIO Delivery Manager did not provide approval of deliverables within the 10 day time requirement.

12. The Province reimbursed the Vendor for travel expenses without requesting receipts to verify the accuracy or existence of the expenses. A subsequent review of travel costs by the Vendor resulted in a $22,078 credit to the Province.

Evaluation of Decision to Terminate the Integrated Case Management System Contract

13. There was no documented legal assessment undertaken to determine the strength of the Provincial position to claim a breach of contract under Section 10.3 of the Procurement Agreement.

14. The decision to terminate was based on an Information Note that underestimated the anticipated amounts that would be paid to the Vendor up until contract termination.

15. The Vendor received payment of approximately $506,000 for professional services and $81,000 for travel and living expenses for work undertaken during the 60 day notice period.

16. The Integrated Case Management System obtained from Nova Scotia (LaMPSS) cost the Province $4.9 million to implement. However, the Province incurred expenditures totaling $14.2 million related to the implementation of an integrated case management system that met the needs of the Department.

17. $4.7 million in incremental costs associated with acquiring and modifying the Labour Market Programs Support System obtained from Nova Scotia were covered by unused Labour Market Agreement program funding.

Recommendations

1. AES should review its application and adjudication procedures relating to individuals and employers wishing to partake in Part II Employment Benefits to ensure the processes are in compliance with program policies established under the LMDA.

2. AES should ensure that individuals applying to partake in Part II Employment Benefits provide sufficient information to substantiate the accuracy, existence, and completeness of their monthly household incomes.

3. OCIO should conduct an additional evaluation of proposed costs submitted by bidders when there is significant disparity in proposal costs to assist in identifying potential misunderstandings or errors in the original RFP or received proposals.

4. OCIO should ensure compliance with all terms and conditions of Procurement Agreements with vendors.

5. The Province should undertake thorough legal and financial assessments in instances where there may be potential breaches of the terms and conditions of legal agreements.

Objectives and Scope

Objectives

The objectives of our review were:

1. To determine whether the Department of Advanced Education and Skills (AES) is managing Part II – Employment Benefits of the Labour Market Development Agreement (LMDA) in accordance with program policies;

2. To determine whether:

    a) the request for proposal (RFP) and contract awards related to the Integrated Case Management System (ICMS) Project were conducted in accordance with the provisions of the *Public Tender Act* and the *Public Tender Regulations, 1998*, and

    b) the bids were appropriately evaluated;

3. To determine whether payment and monitoring activities related to the ICMS Project were conducted in accordance with the terms of the Procurement Agreement and certification procedures; and

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Scope

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2. Targeted Wage Subsidies

Our review of the ICMS Project covered the period September 2009 to August 2011. We reviewed the September 2009 issuance of the RFP, the awarding of the contract in August 2010, the work performed under the contract to the spring of 2011, and the termination of the contract in April 2011.

We completed our reviews in December 2014.

Background

Employment Benefits and Support Measures

AES has a mandate to ensure the Province has highly educated graduates and skilled workers available for the economy. AES has four lines of business:

- employment support and career services;
- labour market development and immigration;
- post-secondary education and learning; and
- policy development, review and input on cross-government initiatives.

From 1996 until 2009, Employment Benefits and Support Measures (EBSMs) were delivered by Human Resources Development Canada (HRDC) as part of the *Employment Insurance Act (EI Act*). On September 4, 2008, HRDC devolved its labour market development responsibilities to the Province with the signing of the LMDA. The LMDA came into effect on November 2, 2009.

Canada provides an annual contribution to the Province to fund LMDA programs.

EBSMs are part of the employment insurance system and assist individuals to return to work and reduce their dependency on Employment Insurance (EI) and provincial income assistance:

- Employment Benefits are designed to assist individual clients to develop and implement a plan to return-to-work. The focus is on providing assistance with skills development, wage subsidies, job creation and self-employment. Employment Benefits are available to eligible participants, including active and former EI claimants.
- Support Measures are designed to facilitate community-based delivery of employment services and to assist community level partners to enhance employment prospects in their area and are available to all unemployed individuals.

Integrated Case Management System Project

As a result of LMDA devolution, the Province required a software solution to assist in the delivery of EBSMs. To minimize interruption, and assist in the transfer of responsibilities, the Province and Canada signed an "*Interim Corporate Management Agreement*" on October 22, 2009. This agreement provided the Province with three years of access and utilization of Canada's case management system in order to administer EBSMs with the expectation that by October 31, 2012, the Province would then "*go live*" with its own ICMS. To assist with the costs of designing and implementing an ICMS, the Province signed a Supplementary Agreement with Canada on August 5, 2010. This agreement covered eligible system development costs between April 1, 2010 and March 31, 2012 to a maximum of $8 million.

On September 18, 2009, the Office of the Chief Information Officer (OCIO) issued an RFP to acquire a Commercial-Off-The-Shelf (COTS) software solution for the purposes of meeting the ICMS business requirements of the LMDA. The RFP also included professional services relating to the software's configuration, customization, integration, data conversion, training, and maintenance.

Three bids were received and, after evaluating all three proposals, the RFP Evaluation Committee recommended that one of the submitted bids be chosen to implement an ICMS. On August 5, 2010, a Procurement Agreement was signed with the successful bidder and work on the ICMS Project commenced shortly thereafter.

Detailed Observations

1. Part II Employment Benefits

Objective

To determine whether the Department of Advanced Education and Skills is managing Part II – Employment Benefits of the Labour Market Development Agreement in accordance with program policies.

Conclusion

For the samples selected, we found that in some instances AES was not properly managing Part II - Employment Benefits in accordance with program policies established under the LMDA.

Overview

The *EI Act* states that the purpose of Part II - Employment Benefits is to help maintain a sustainable employment insurance system through the establishment of employment benefits for insured participants and the maintenance of a national employment service.

As part of its mandate under the LMDA, AES delivers a wide range of Benefits and Measures to assist EI Clients and other unemployed individuals, in finding, keeping and maintaining employment. The four Employment Benefits and two Support Measures delivered by AES are as follows:

Employment Benefits

- *Skills Development (SD)* helps participants obtain employment skills, through providing financial assistance for education and training. A contribution agreement made between AES and the client provide the client with financial assistance to access training as part of a return-to-work action plan. Where appropriate, clients are expected to share in some of the costs of their training.

- *Job Creation Partnerships (JCP)* provides insured participants with opportunities to gain work experience that will lead to ongoing employment. JCPs are designed to create incremental and meaningful work opportunities for clients through partnerships involving employers and/or community groups.

- *Targeted Wage Subsidies (TWS)* assist participants to obtain on-the-job experience by providing employers with a financial contribution towards the wages of participants they hire. This is designed to encourage employers to hire individuals they would not normally hire in the absence of a subsidy. The subsidy may be up to 78 weeks. The subsidy covers a percentage of the wages and the mandatory employment related costs. Under normal circumstances, the wage subsidy should not exceed 60% of the total wages paid to the individual for the period of the agreement.

- *Self-Employment Assistance* provides financial assistance and business planning advice to help participants start their own business.

Support Measures

- *Employment Assistance Services* were provided by third-party service providers through negotiated agreements to help unemployed individuals become employed.

- *Labour Market Partnerships (LMPs)* provides funding to support employers, employer or employee associations, community groups and communities in developing and implementing labour market strategies and activities for dealing with labour force adjustments and meeting human resource requirements. LMPs may also be used to provide assistance for employed persons who are facing loss of employment.

The Employment and Training Programs Division of AES is responsible for overseeing the administration of these EBSMs under the LMDA.

Table 1 summarizes the annual revenue and expenses associated with the Province's delivery of EBSMs for the fiscal years 2010 through 2014.

Table 1

Department of Advanced Education and Skills
Labour Market Development Agreement
Summary of LMDA Revenue and Expenses
For the Year Ended March 31

NL Benefits and Support Measures	2010*	2011	2012	2013	2014
Federal Contribution	$69,979,424	$146,012,000	$131,944,000	$130,405,000	$129,219,000
Expenses					
Employment Benefits	62,073,480	125,990,302	106,893,128	104,750,958	108,941,259
Support Measures	7,477,187	19,608,946	24,866,576	22,964,854	7,451,986
Total Expenses	69,550,667	145,599,248	131,759,704	127,715,812	116,393,245
Other items	305,754	309,018	104,608	(199,967)	(636,495)
Excess Contributions	**$123,003**	**$103,734**	**$79,688**	**$2,889,155**	**$13,462,250**

Source: Canada-Newfoundland and Labrador LMDAs Audited Statements of Operations
*Includes only 5 months of provincial delivery of the EBSMs (November 2, 2009 to March 31, 2010)

Finding

1. Since the Province assumed responsibility for delivery of benefits under the LMDA, almost $600 million has been directed to enhancing employment skills for Newfoundlanders and Labradorians in the four and a half years since 2009. The Federal Government managed the LMDA programs for the 13 year period prior to 2009.

Table 2 details the number of annual client interventions by benefits and support measures.

Table 2

Department of Advanced Education and Skills
Labour Market Development Agreement
Number of Annual Client Interventions
By Benefits and Support Measures
For the Year Ended March 31

	Number of Client Interventions				
	2010*	**2011**	**2012**	**2013**	**2014**
Employee Benefits	11,306	8,913	7,652	6,683	7,440
Support Measures	16,960	14,020	12,605	12,369	11,000
Total Number of Client Interventions	**28,266**	**22,933**	**20,257**	**19,052**	**18,440**

Source: AES
* Includes client interventions initiated before the Province became responsible for the delivery of the EBSMs

This section provides findings related to our objective to determine whether AES is managing Part II - Employment Benefits in accordance with program policies and to assess whether there are processes in place for managing the participants' program eligibility and financial assessment considerations.

In particular we focused on the following benefits:

A. Skills Development

B. Targeted Wage Subsidies

1A. Skills Development

Introduction

To qualify for the Skills Development program, individuals must meet the definition of an "*insured participant*" under Section 58.(1) of the EI Act (i.e. is an individual who is currently receiving Regular or Fishing EI benefits or has received Regular or Fishing EI benefits in the last 36 months, or an individual who has received EI Maternal or Parental benefits in the last 60 months following the birth or adoption of a child, and who wishes to re-enter the labour force).

EI clients wanting to partake in the Skills Development Benefit program are required to complete an application for financial assistance and a Return to Work Action Plan (RTWAP). Both documents are integral components in the assessment process, as they formulate the basis upon which Client Service Officers (CSO) and Client Service Managers (CSM) assess whether the applicants possess barriers to employment as the result of a lack of marketable skills.

Section 4 of the *Program Policy for Skills Development* details the types of eligible training that the Skills Development Benefit program will support. Training must generally be full-time, lead to a certificate, diploma or degree and provide EI clients with skills training in an occupation with a strong probability of sustained employment.

Financial assistance for clients participating in the Skills Development program under the LMDA is a discretionary benefit and up to July 2013, was determined through a Negotiated Financial Assistance model. Under this model, the Departmental CSOs and CSMs would negotiate the amount of financial assistance with EI clients to cover both the living costs and the direct costs of training (e.g. tuition and instructional costs, dependent care, disability costs, transportation) based on the individual financial circumstances of EI clients applying for Skills Development benefits. Consequently, on the application for financial assistance, an EI client was required to disclose their monthly household income, other sources of funding, basic living costs (e.g. rent, food, utilities), all incremental living costs resulting from the client's RTWAP, as well as the direct costs associated with being enrolled in the skills training program.

Case File Documentation

We reviewed a sample of 25 EI clients participating in the Skills Development Benefit program and assessed the samples for program policy compliance. We found instances of missing or incomplete documentation in the case files. Of the 25 Skills Development participants sampled, 2 of 25 (8%) RTWAPs, in our view, did not clearly convey that the participants displayed barriers to employment.

Finding

2. For the files reviewed, completed Return to Work Action Plans in some instances did not clearly demonstrate that participants possessed barriers to employment.

Verification of EI Clients' Monthly Living and Financial Information

The Application for Financial Assistance requires skills development applicants to provide documentation to support all the costs claimed on the application. CSOs check applicant expenses and income claimed for reasonableness.

To assess the degree to which CSOs review client-submitted financial information, we reviewed our sample of 25 case files and found the following:

- 4 of 25 (16%) case files possessed insufficient third party information to support the accuracy and existence of the claimed income and expense amounts that determine the level of program funding for basic living costs and other incremental costs;

- 4 of 12 (33%) files that claimed dependency benefits did not have documentation to confirm the existence of eligible dependents;

- 1 of 12 (8%) files that claimed dependency benefits did not contain a letter from the dependent care provider specifying the service dates, cost or level of care to be provided; and

- 1 case file related to an EI client who claimed an incremental cost due to disability needs, however, the substantiation of the EI client's disability costs was inadequate.

Based on the files we reviewed, there was no formalized process in place to assess the completeness of the monthly household/family incomes when negotiating the level of financial assistance to be provided to Skills Development Participants.

Finding

3. For the files reviewed, AES staff were not adequately verifying the client-submitted costs and income sources for accuracy, existence and completeness when negotiating the level of funding for monthly living and incremental costs.

Tuition Assistance

Skills Development clients enrolled in an institutional training program are usually provided a grace period to decide if they will remain in their training program. In many cases, AES may be eligible to receive prorated refunds of the tuition paid on behalf of the participants who withdraw from their program.

Our review found that CSO progress reports do not coincide with program grace period cut-off dates. As a result, potential tuition refunds could go undetected by AES staff. Furthermore, we found that of the 25 Skills Development case files sampled, 10 (40%) did not include training updates regarding client attendance to allow staff to assess possible tuition refunds.

Finding

4. For the files reviewed, AES did not adequately monitor the attendance of participants in funded training programs. As a result, AES may also be missing opportunities to maximize opportunities for tuition refunds.

1B. Targeted Wage Subsidies

The objective of the TWS program is to encourage employers to hire individuals whom they would not normally hire in the absence of a subsidy. TWS is intended to assist unemployed individuals to obtain employment by providing employers with financial assistance towards their wages.

To qualify for the TWS benefits program, unemployed individuals must demonstrate barriers to employment and complete a RTWAP that identifies the appropriate wage subsidy and work experience required. The RTWAP states the employment barriers and serves as a foundation for the appropriate intervention required. In addition, eligible unemployed individuals must meet the definition of an insured participant pursuant to *Section 58* of the *EI Act*.

Program policy states "*that the subsidy is provided to encourage employers to hire someone for a job vacancy that they would not normally hire in the absence of a subsidy*." The Policy also states "*the program is not intended to resolve an employer's human resource or cash flow problems"*.

We reviewed three TWS case files and found that one client was funded at a subsidy rate higher than what was provided for in the contribution agreement which lead to an overpayment of $1,258.

Finding

5. For the files reviewed, we found one instance where a Targeted Wage Subsidy was funded at an amount higher than what was provided for in the contribution agreement which lead to an overpayment of $1,258.

2. Integrated Case Management System Contract Award

Objective

To determine whether:

a) the RFP and contract awards related to the Integrated Case Management System Project were conducted in accordance with the provisions of the *Public Tender Act* and the *Public Tender Regulations, 1998*, and

b) the bids were appropriately evaluated.

Conclusion

a) The RFP and contract award related to the ICMS Project was conducted in accordance with the provisions of the *Public Tender Act* and the *Public Tender Regulations, 1998.*

b) The bids received in response to the RFP related to the ICMS Project were properly evaluated. However, there was no additional evaluation undertaken to assist in identifying potential misunderstandings or errors in the original RFP or received proposals as a result of a significant disparity in costs between the proposal from the vendor and other qualified bidders.

Overview

On September 18, 2009, the OCIO, on behalf of AES, advertised an RFP to acquire a Commercial-Off-The-Shelf (COTS), case management software and implementation solution to enable AES to administer the devolved labour market programs.

The RFP closed on November 9, 2009. Table 3 details the proposed costs of the three bids received.

Table 3

Department of Advanced Education and Skills
Labour Market Development Agreement
RFP Cost Summary

Name	Base Cost of Proposal
First Bidder	$9,119,200
Second Bidder	$16,925,400
Third Bidder	$21,691,000

Source: OCIO

The RFP Evaluation Committee evaluated the three proposals using a five stage evaluation process. The first bidder, with an estimated cost to the Province of $13.62 million (Table 4), was the successful bidder. The first bidder (the Vendor) proposed the utilization of Siebel-based/Oracle software and on August 5, 2010, the Province entered into a Procurement Agreement with the Vendor.

Table 4

Department of Advanced Education and Skills
Labour Market Development Agreement
Total Estimated Cost of the ICMS Project

Cost Component Description	Amount
Contract with the Vendor	$6,940,000
Software, Support and Maintenance	2,179,200
Subtotal	**9,119,200**
Departmental Resources	4,500,000
Total Estimated Cost	**$13,619,200**

Source: OCIO

Our review in this area considered the following:

- the RFP call;
- the receipt and scoring of proposals;
- the award of the RFP; and
- the detailed Procurement Agreement which was negotiated with the Vendor.

We identified findings in the following areas:

A. Compliance with the *Public Tender Act* and *Regulations*

B. Proposal Evaluation

2A. Compliance with the *Public Tender Act* and *Regulations*

As part of our review of the ICMS Project, we examined compliance with the *Public Tender Act* and the *Public Tender Regulations, 1998*.

We reviewed files retained by OCIO to support the RFP process. Our review of procurement files revealed that OCIO managed the RFP in accordance with the *Public Tender Act* and the *Public Tender Regulations, 1998.*

Finding

6. The OCIO conducted the contract award process in accordance with the *Public Tender Act* and the *Public Tender Regulations, 1998.*

2B. Proposal Evaluation

Introduction

As part of its evaluation process, the RFP Evaluation Committee (the Committee) evaluated all submitted proposals and awarded points based on five criteria areas. Table 5 summarizes the scoring system used by the Committee and details the allowable minimum and maximum scores for each scored criteria.

Table 5

Department of Advanced Education and Skills
Labour Market Development Agreement
RFP Evaluation Criteria

Criteria	Min. Score	Max. Score	%
Section 3.0: Proponent Information	2,520	3,600	15%
Section 4.0: Business Requirements	3,360	4,800	20%
Section 5.0: Information Management, Technical & General Requirements	2,520	3,600	15%
Section 6.0: Financial Proposal Requirements	-	6,000	25%
Total Submission Score	**12,600**	**18,000**	**75%**
Demonstration Score	-	6,000	25%
Total Score	**12,600**	**24,000**	**100%**

Source: OCIO

The RFP Evaluation Report indicated that "*the Proposal judged to represent the lowest overall cost to the Government will be awarded the full financial evaluation score of 25%. All other Proposals will be awarded a prorated score based on the following formula:*

*(Lowest Cost/Proponents Cost)*25%* [*24,000]"

Proposal Costs

The proposal cost component, at 25%, was the most significant element of the submission evaluation process. As such, this increased the risk that bids with understated costs would receive scoring points which may be unwarranted. A thorough understanding of the Financial Proposal Requirements of each bid was crucial. Given the significant difference in costs between the proposal from the vendor and other qualified bidders (Table 6), the Committee should have undertaken an additional evaluation to assist in identifying potential misunderstandings or errors in the original RFP or received proposals.

Table 6

Department of Advanced Education and Skills
Labour Market Development Agreement
Cost Breakdown of Proposals (excluding departmental resource costs)

Project Area	Vendor	Second Bidder	Third Bidder
Software	$1,383,200	$5,350,000	$5,965,000
Additional Software (Plug-ins)	-	$227,500	$954,000
Professional Services	$4,222,500	$7,933,400	$5,457,000
Customization	$282,500	$442,700	$1,264,000
Interface Development	-	-	$318,000
Data Conversion	$225,000	$182,300	$753,000
Training	$170,000	$170,000	-
Travel & Accommodations	$730,000	$359,000	$1,250,000
Office Rental Space	$370,000	$36,500	$415,000
QA & UAT	$360,000	-	-
Change Management	$230,000	-	$1,157,000
Security, Privacy & Financial Controls	$350,000	-	-
Project Contingency	-	-	$1,342,000
Support & Maintenance (2 years)	$796,000	$2,224,000	$2,816,000
Total Costs	**$9,119,200**	**$16,925,400**	**$21,691,000**
Number of Times Higher than the Lowest Bid	**N/A**	**1.9**	**2.4**

Source: OCIO

The proposed costs from the second and third bidders were 1.9 and 2.4 times higher than that of the Vendor. Based on our review of the RFP Evaluation Report, documentation did not indicate that the Committee performed any additional evaluation of the proposed costs submitted by the Vendor, given the wide disparity in proposed costs. As a result, the Committee did not adequately manage the risk of awarding unwarranted RFP points to the proposal with the lowest estimated cost.

Finding

7. The RFP Evaluation Committee did not adequately assess the risk associated with the estimated project costs from the Vendor before scoring the Financial Proposal Requirements section of their proposal even though the second bidder was 1.9 times higher than the Vendor and the third bidder was 2.4 times higher.

Proof of Concept Demonstration

Section 2.7.5 of the RFP indicated that "*at a minimum, the top Proponent with the best combined score on rated requirements and financial score at their expense will be called upon, on one or more occasions, to demonstrate their product (proof of concept) in support of their Proposal to the Evaluation Committee"*. Bidders possessing a minimum score of 12,600 prior to the awarding of proof of concept points qualified to be invited for a proof of concept demonstration. Table 7 provides a breakdown of the scores of each bid before and after proof of concept points were awarded.

Table 7

Department of Advanced Education and Skills
Labour Market Development Agreement
Scoring Summary

Criteria	Vendor	Second Bidder	Third Bidder
Section 3.0: Proponent Information	3,420	3,204	3,144
Section 4.0: Business Requirements	4,250	3,550	3,420
Section 5.0: Information Management, Technical & General Requirements	3,245	3,245	3,159
Total Before Financial Proposal Requirements Score	10,915	9,999	9,723
Section 6.0: Financial Proposal Requirements	6,000	3,233	2,522
Total Before Proof of Concept Score	16,915	13,232	12,245
Proof of Concept Score	5,100	N/A	N/A
Total Score	**22,015**	**13,232**	**12,245**

Source: OCIO

The Vendor possessed the highest pre-proof of concept score and was invited to demonstrate their proposal. The demonstration took place from December 14 to 18, 2009. The Committee initially scored the Vendor's proof of concept demonstration at 4,680 (78%) because the demonstration session did not focus on labour market programming business requirements but instead focused on income support scenarios. Due to the Committee's "*concern around* [the Vendor]*'s proposed solutions' ability to meet labour market programming requirements*", the Vendor was asked to provide another demonstration on February 2, 2010 and received an adjusted score of 5,100 (85%).

The second place bidder qualified to be invited to provide a proof of concept demonstration by virtue of the fact that they scored 13,232, which was above the minimum requirement of 12,600; however, they were not invited to provide a demonstration. Inviting the other qualified bidder to demonstrate their proposal could have assisted the Committee in better evaluating the two qualifying proposals and identifying potential deficiencies in the proposals and in the RFP itself. OCIO officials indicated that due to the significant costs involved, bidders have indicated a preference not to provide a proof of concept demonstration unless there is a reasonable likelihood that the results of the demonstration could be a deciding factor in selecting the successful bidder. The Committee felt that after scoring the business and financial elements of the proposals, the point spread between the Vendor and the second bidder was large enough not to warrant inviting the second bidder for a proof of concept demonstration.

3. Integrated Case Management System Payment and Monitoring Activities

Objective

To determine whether payment and monitoring activities related to the ICMS Project were conducted in accordance with the terms of the Procurement Agreement and certification procedures.

Conclusion

Payment and monitoring activities were not conducted in accordance with either the Procurement Agreement or certification procedures.

Overview

Schedule A of the Procurement Agreement between the Province and the Vendor detailed the scope of work that was to be provided in order to make available a COTS software solution to deliver the LMDA programs. The specific way in which the scope of work was to be achieved was through preparation of individual Statements of Work (SOW).

SOW, as described in the Procurement Agreement, were the initiating documents that formulated the amount the Province would be committed to pay for work rendered on the ICMS Project. Prior to executing any work relevant to the scope of work detailed on Schedule A, SOW were to be prepared by the Vendor and forwarded to the OCIO and AES for approval. Once approved, the SOW were to be used as the facilitating documents for the payment of Vendor invoices.

The Procurement Agreement prescribed a process for preparing and utilizing the SOW that provided for a high degree of vendor accountability. Appendix A of the Procurement Agreement required the following items be included on each SOW:

- the services to be provided;
- the deliverables to be provided (if applicable);
- the price and payment methodology; and
- a resource management plan detailing the Vendor personnel required to complete the deliverables.

In essence, every mutually-approved SOW was designed to become a more refined contract, possessing time and materials and/or fixed price commitments specific to the individual phase of the Project. Over the course of the ICMS Project, four SOW were negotiated with the Vendor. Table 8 provides a breakdown of the four SOW.

Table 8

Department of Advanced Education and Skills
Labour Market Development Agreement
Statements of Work Signed by both Parties

SOW #	SOW Description	Category	Amount
#1	Planning	Professional Services	$358,560
		Travel	70,000
		Total:	**428,560**
#2	Design (Part I)	Professional Services	597,200
		Travel and Living	132,000
		Total:	**729,200**
#3	Design (Part II)	Professional Services	2,303,720
		Travel	419,000
		Total:	**2,722,720**
#4	Project Accommodations	Accommodations	141,162
		Total:	**141,162**
		TOTAL:	**$4,021,642**

Source: OCIO

The ICM Project Management Office played a critical role in all phases of the Project, as this functional division contained the lead technical representatives from the Province on the Project, the AES Project Manager and the OCIO Delivery Manager. These two individuals were integral to project advancement, as all negotiated SOW and agreed-upon deliverables required authorization from both of these managers. As well, all submitted invoices were to be reviewed and certified by the AES Project Manager.

We reviewed project payments to ensure each payment was properly supported, numerically accurate, and properly authorized in accordance with the Procurement Agreement.

Support for payments examined included:

- analysis of SOW;
- review of invoices for accuracy and certification;
- agreed invoices to relevant SOW; and
- agreed billed rates to the Procurement Agreement and SOW.

Table 9 details the payments made to the Vendor for work undertaken on the ICMS Project.

Table 9

Department of Advanced Education and Skills
Labour Market Development Agreement
Payments to the Vendor

Date	Related SOW	Amount
Fiscal Year 2010-11		
February 1, 2011	1 & 2	$ 803,655
March 29, 2011	1, 2 & 3	2,051,733
Total		**2,855,388**
Fiscal Year 2011-12		
April 26, 2011	2 & 3	449,423
April 29, 2011	4	132,000
May 3, 2011	4	9,162
July 27, 2011	3	102,080
August 19, 2011	3	1,332
Total		**693,997**
Total Payments		**$3,549,385**

Source: Financial Management System

Approval of Statements of Work

Obtaining mutual agreement on the SOW prior to commencing work was required by the Procurement Agreement and was fundamental for achieving vendor accountability and the effective management of project costs.

The Procurement Agreement provided that work was to commence only after a relevant SOW was signed by both parties. Appendix A of the Procurement Agreement states: "*Once the Statement of Work has been approved and signed off in writing by both Parties, Vendor will execute that Approved Statement of Work subject to and in accordance with the terms and conditions of this Agreement*".

We found that all four SOW received OCIO authorization after work and costs relevant to each SOW were incurred (Table 10). Although no payments were made to the Vendor prior to the finalization of the SOW, the degree to which the Province was able to manage the mutually-agreed-upon costs and deliverables diminished as additional time and costs were incurred before finalizing the SOW.

Table 10 details the value of the work and costs incurred on the Project prior to the finalization of the SOW. As a percentage of total payments made to the Vendor (exclusive of HST), approximately 82% of the Project's value was incurred prior to OCIO coming to an agreement with the Vendor on costs and deliverables.

Table 10

Department of Advanced Education and Skills
Labour Market Development Agreement
Value of Work and Costs Incurred Prior to OCIO Authorization of Statements of Work

SOW #	Date Initial Work/Costs Incurred	Finalization Date of SOW	Payment Date(s)	Category	Pre-Tax Value of Costs Incurred Before Finalization of SOW
#1	June, 2010	October 25, 2010	February 1, 2011 March 29, 2011	Professional Services	$321,120
				Travel and Living	61,273
				Subtotal:	**382,393**
#2	July 2010	October 25, 2010	February 1, 2011 March 29, 2011 April 26, 2011	Professional Services	396,215
				Travel and Living	116,074
				Subtotal:	**512,289**
#3	November 2010	February 22, 2011	March 29, 2011 April 26, 2011 July 27, 2011 August 19, 2011	Professional Services	1,634,915
				Travel and Living	258,211
				Subtotal:	**1,893,126**
#4	July 2010	April 13, 2011	April 29, 2011 May 3, 2011	Accommodations	138,221
				Subtotal:	**138,221**
				Total Payments:	**$2,926,029**

Source: OCIO

Finding

8. All Statements of Work (SOW) were approved after work had commenced. As a result, the Province diminished its ability to manage project costs and deliverables by allowing approximately 82% of the work to be completed by the Vendor before obtaining mutual agreement on the terms of the SOW.

Monitoring of Deliverables

Deliverables are the goods or services that are provided upon the completion of a project or phase of a project. The Procurement Agreement states that, "*The Client and the Vendor shall enter into statements of work ("Statements of Work" or a "Statement of Work") that set out in more precise detail the exact services (the "Services") and deliverables (the "Deliverables") to be provided by the Vendor*".

Deliverables completed by the Vendor were required to have written approval of both the AES Project Manager and the OCIO Delivery Manager in accordance with section 2.7 of the Procurement Agreement.

The OCIO and AES were required to complete their review of a deliverable within ten business days and provide the Vendor with either written approval or a written statement of the deficiencies preventing approval.

We conducted a review to determine if the Vendor provided the deliverables specified in the SOW and whether AES and OCIO appropriately reviewed what was delivered by the Vendor. Our review found the following:

- The AES Project Manager and OCIO Delivery Manager did not confirm their acceptance in writing of four deliverables specified on SOW #3;

- Three of seven deliverables specified on SOW #3 were never completed by the Vendor, even though payments totaling $2,427,222, 89% of the SOW value, were made under this SOW; and

- The AES Project Manager did not provide approval for most of the deliverables within the 10 day time requirement, thereby diminishing the effectiveness of the deliverable management process.

Findings

9. The AES Project Manager and OCIO Delivery Manager did not confirm their acceptance in writing of four deliverables specified on SOW #3.

10. Three of seven deliverables specified on SOW #3 were never completed by the Vendor.

11. The AES Project Manager and OCIO Delivery Manager did not provide approval of deliverables within the 10 day time requirement.

Review of Travel and Accommodation Costs

Schedule B of the Procurement Agreement estimated that total travel and accommodation costs for Vendor employees over the 23 month work period would be $730,000. Both the Procurement Agreement and relevant SOW mandated that travel and accommodation expenses be billed at cost and be in accordance with the Province's polices governing travel expenses. We reviewed Vendor invoices supporting travel and accommodation costs and found the following:

- The AES Project Manager approved the vendor-billed travel and accommodation costs without comparing invoiced amounts to supporting documentation. Our review of documentation showed that the Province did not require the Vendor to submit supporting travel documentation (i.e. original receipts to support airfare, hotel, "miscellaneous" items) with their invoices. Therefore, the Province was unable to determine if the billed travel reimbursements were appropriately incurred costs of the Project.

- Monthly living allowance rates ranged from $2,800 to $3,540, however, there was no evidence to show the mutual pre-approval between the Vendor the ICM Project Management Office of the monthly allowance rates.

- Although the Vendor intended to partner with the Province and come up with "*alternative delivery models to reduce travel*…", certain employees of the Vendor received significant travel reimbursements throughout the course of the Project. In one case, an employee incurred $72,560.52 in travel costs over a 9 month period.

- By December 2010, OCIO determined that travel and accommodation costs were being incurred at a rate of 20% of professional fee billings (projected to be at 15%). Consequently, OCIO conducted its own audit of travel and accommodation costs. After a detailed review by the Vendor, the Province received a credit for $22,078 in travel related adjustments.

Finding

12. The Province reimbursed the Vendor for travel expenses without requesting receipts to verify the accuracy or existence of the expenses. A subsequent review of travel costs by the Vendor resulted in a $22,078 credit to the Province.

4. Evaluation of Decision to Terminate the Integrated Case Management System Contract

Objective

To determine whether the decision to terminate the Procurement Agreement for the ICMS Project was appropriately evaluated.

Conclusion

The decision to terminate the Procurement Agreement was not properly evaluated.

Overview

By October 2010, two months after entering into the contract with the Vendor, scoping issues emerged related mainly to integration with the Provincial financial management system (FMS). According to an information note prepared by Government in early 2011"*…considerable functionality of the Siebel system that* [the Vendor] *included in its written bid and subsequently demonstrated in a week-long session in December 2009 is, in fact, no longer included by* [the Vendor] *within the scope of this project but, rather, is now defined by* [the Vendor] *as 'capability' of the system for potential future build."*

The Procurement Agreement provided two options to remedy disagreements:

- Section 10.2 provided a 60-day, no fault termination; and
- Section 10.3 provided a process to give notice in writing of breach of the Procurement Agreement and request a remedy of the breach.

On February 18, 2011, the Province provided the Vendor with a 60 day notice of termination after concluding that the Vendor "*will not complete the work identified in the Scope of Work in the Agreement for the specified bid price*". The contract with the Vendor terminated on April 19, 2011.

We would expect to see documentation that both options available to the Province were examined, which would include:

- Supporting facts;
- Analysis and evaluation;
- Legal opinions; and
- Recommendations.

Decision to Terminate

On February 14, 2011, an Information Note entitled "*Contract Issue with* [the Vendor] *on Integrated Case Management System Project*" was prepared by the AES Project Manager, the Acting Chief Information Officer and the Deputy Minister of Human Resources, Labour and Employment (HRLE), now AES. A copy of the Information Note is attached in Appendix A. The note advised both the Minister of HRLE and the Minister responsible for OCIO, on the "*action being taken to cancel a $6.9 million contract with* [the Vendor] *for information technology professional services as a result of not meeting contractual obligations for the Integrated Case Management System"*

The Province and the Vendor were at odds regarding what was included in the original scope of work. The primary scoping issue dealt with the work in the area of integrating the Siebel software with the existing FMS software used by the Province. In a presentation on January 31, 2011, the Vendor indicated they required additional money to finish the project as they considered FMS integration to be out-of-scope and not included in the Procurement Agreement's initial scope of work.

Based on the original RFP issued by the Province and the Vendor's submitted proposal, there is evidence that FMS integration was included within the original scope of work:

- The RFP states "*the solution must consider Oracle Financials as the primary financial application*" and "*The solution must integrate with Government's Oracle Financial Management solution to create a seamless link between the Proponent's Case Management solution and Oracle Financials. Integration points include areas such as budget management, G/L, A/R (i.e., revenue and collections), A/P (i.e., Payments) and Purchasing (i.e., Service Authorizations)*";

- The RFP states "*The proposed solution must provide seamless end-to-end integration across all solution components, including the ability to move from module to module using a consistent user interface and without requiring additional logins. This tight integration must extend to the interface between the functions of the case management solution…and the Government's financial management solution.*";

- The Vendor proposal termed their overall solution as "*Seamless end-to-end integration across all solution components*" and elaborated further by stating "*As part of the overall solution[,] we are proposing Oracle Fusion Middleware to manage the integration between the different systems and Application Integration Architecture which provides a foundation pack and methodology to accelerate integration initiatives*";

- The Vendor proposal states that "*the solution will encompass a fully integrated financial system that leverages the Government's current financial solution (oracle financials)*";

- The Vendor proposal states "*The proposed solution provides a number of options for integration to Oracle Financials*"; and

- The Procurement Agreement *Scope of Work* states that *"Tight integration is required between the proposed solution and ORACLE Financial Management System (Office of the Comptroller General)"*.

Documentation suggests that the Vendor should have been aware of the FMS integration requirements at the initial phases of procurement and their proposal conveyed their understanding that integration needed to be part of their proposed solution.

The Vendor provided proof of concept demonstrations on two occasions in December 2009 and February 2010. These were designed to ensure the product being proposed met the requirements of the RFP and AES. Based on discussions with OCIO and AES staff, they feel the Vendor did indicate during this evaluation process that integration was included and this was a significant reason for the high scoring for the Vendor.

As part of the evaluation, there was no documented legal assessment undertaken to determine the strength of the Provincial position to claim a breach under Section 10.3 of the Agreement.

In addition, our review of the February 14, 2011 Information Note provided to the Ministers seeking authorization to terminate under Section 10.2 revealed that the Information Note underestimated the amount of anticipated costs that would be paid in total to the Vendor. According to the Information Note, the total anticipated value to be spent under the Procurement Agreement with the Vendor was approximately $2.5 million. However, in the end, the Province paid $3.5 million to the Vendor.

Findings

13. There was no documented legal assessment undertaken to determine the strength of the Provincial position to claim a breach of contract under Section 10.3 of the Procurement Agreement.

14. The decision to terminate was based on an Information Note that underestimated the anticipated amounts that would be paid to the Vendor up until contract termination.

Work Authorization Timing

The February 18, 2011 termination letter stated that during the 60 day notice period, *"...both* [the Vendor] *and provincial government officials may continue to collaborate on planning and design matters so as to preserve the value of the work that has been completed on the project to date."* On February 21, 2011, three days after providing a notice to terminate, SOW #3, valued at $2,722,720 received provincial authorization.

SOW #3 governed Part II of the design phase and spanned a work period from November 1, 2010 to April 29, 2011. Although a significant portion of the work had already been incurred prior to provincial authorization on February 21, 2011, the Vendor did receive payment for professional hours worked past February 21, 2011 of approximately $506,000. The Vendor also received approximately $81,000 for travel and living expenses for the months of March and April 2011.

Finding

15. The Vendor received payment of approximately $506,000 for professional services and $81,000 for travel and living expenses for work undertaken during the 60 day notice period.

Value of Work Completed

The contract with the Vendor terminated on April 19, 2011. In the end, the Province incurred $8,468,110 in project expenditures and eventually wrote-off all capitalized costs associated with the ICMS Project.

As a result of terminating the Procurement Agreement, additional costs were incurred as the Province still required an ICMS solution to administer the EBSMs. Consequently, on February 2, 2013, Cabinet granted approval for the Minister responsible for OCIO to enter into a software license agreement with the Province of Nova Scotia, for $1.00, for the rights to implement and modify Nova Scotia's Labour Market Programs Support System (LaMPSS). In order to modify LaMPSS for the Province, Cabinet authorized up to $5 million be spent on implementing LaMPSS.

On February 28, 2014, the Province commenced its use of LaMPSS. The LaMPSS project cost a further $4.9 million. To fund the acquisition of LaMPSS, the Province, utilized $4.7 million in funding provided under the Canada-Newfoundland and Labrador Labour Market Agreement (LMA). The purpose of the LMA is to fund labour market programs that "*enhance labour market participation*" for both non-EI eligible individuals as well as low skilled employed individuals. By utilizing the LMA to cover $4.7 million in LaMPSS costs, the Province reduced available funding for labour market programs designed to assist unemployed social assistance recipients, immigrants, persons with disabilities, older workers, youth, Aboriginal peoples, previously self-employed individuals and low skilled employed individuals with improved labour market participation.

Another incremental expenditure incurred by the Province related to the signing of two extension agreements with Canada that extended the duration of the Interim Corporate Management Agreement. By extending the duration of this agreement, the Province retained access and usage of Canada's case management system until February 28, 2014. The cost for the two amendments totaled $874,623 and was funded using LMDA program funding.

Table 11 details the total project costs and the related funding to obtain an integrated case management solution.

Table 11

Department of Advanced Education and Skills
Labour Market Development Agreement
Project Costs and Funding

	Amount
Project Costs	
ICMS Project Costs	$8,468,110
Extension Agreements with Canada	874,623
Replacement LaMPSS Product	4,863,357
Total Project Costs	**$14,206,090**
Project Funding	
Federal Contribution Under the LMDA IT Supplementary Agreement	$7,987,471
Federal Contribution Funded Under the LMA	425,000
Federal ICMS Funding Provided Through Devolution Agreements	**8,412,471**
Extension Agreement Costs Funded From LMDA Administration Costs	874,623
LaMPSS Costs Funded From LMA Program Funds	4,706,668
Program Funding Utilized to Cover Incremental Project Costs	**5,581,291**
Additional Provincial Funding	**212,328**
Total Project Funding	**$14,206,090**

Source: AES

Findings

16. The Integrated Case Management System obtained from Nova Scotia (LaMPSS) cost the Province $4.9 million to implement. However, the Province incurred expenditures totaling $14.2 million related to the implementation of an integrated case management system that met the needs of the Department.

17. $4.7 million in incremental costs associated with acquiring and modifying the Labour Market Programs Support System obtained from Nova Scotia were covered by unused Labour Market Agreement program funding.

Recommendations - LMDA

1. AES should review its application and adjudication procedures relating to individuals and employers wishing to partake in Part II Employment Benefits to ensure the procedures are in compliance with the program policies established under the LMDA.

2. AES should ensure that individuals applying to partake in Part II Employment Benefits provide sufficient information to substantiate the accuracy, existence, and completeness of their monthly household incomes.

3. OCIO should conduct an additional evaluation of proposed costs submitted by bidders when there is significant disparity in proposal costs to assist in identifying potential misunderstandings or errors in the original RFP or received proposals.

4. OCIO should ensure compliance with all terms and conditions of Procurement Agreements with vendors.

5. The Province should undertake thorough legal and financial assessments in instances where there may be potential breaches of the terms and conditions of legal agreements.

Department Response

Recommendation 1

Advanced Education and Skills (AES) should review its application and adjudication procedures relating to individuals and employers wishing to partake in Part II-LMDA Employment Benefits to ensure processes are in compliance with program policies established under the LMDA.

AES Response

The Department appreciates the comments of the Auditor General and acknowledges the need for continuous improvement in the area of procedural compliance with program policies and is undertaking a number of measures aimed to strengthen application and adjudication procedures.

Recommendation 2

AES should ensure that individuals applying to partake in Part II-LMDA Employment Benefits provide sufficient information to substantiate the accuracy, existence and completeness of their monthly household incomes.

AES Response

Departmental procedures require that individuals applying for Part II-LMDA Employment Benefits (Skills Development) provide sufficient information to substantiate the accuracy, existence and completeness of their monthly household incomes and expenses. The Department will continue to ensure that these procedures are effective and efficient in order to meet program objectives.

Further, the agreement between the Department and the individual being funded under Skills Development in Schedule D (Financial Terms and Conditions), Section 1.2 provides that the individual agrees to, "…inform the PROVINCE immediately in writing of any other change in your financial situation, family size, or family income during your AGREEMENT PERIOD as this may reduce or increase your eligibility for financial assistance provided under this AGREEMENT."

OCIO Response

3. OCIO should conduct an additional evaluation of proposed costs submitted by bidders when there is significant disparity in proposal costs to assist in identifying potential misunderstandings or errors in the original RFP or received proposals.

   The OCIO followed Government's standard guidelines for RFP evaluation, using 25% weighting on costs which is lowest allocation allowable. This weighting was warranted to ensure 75% was allocated to other areas (e.g. non-financial areas such as vendor experience, proposed vendor team, business requirement fit, technical requirement fit).

   Submitted financial proposals were analyzed by an RFP Evaluation Committee, comprised of senior representatives from multiple departments. This Commssion reviewed one-time implementation versus recurring post-implementation cost, vendor resource costs, required Government resourcing, and vendor effort versus software costs. Vendor costs were also constracted against the proposed project schedule (project plan), scope and level of vendor involvement (compared to that of Government). Along with challenging assumptions at the vendor's demonstration, the RFP Committee felt its analysis took into account the overall ownership costs and was thorough in approach.

   The strict analysis of total costs at an aggregate level does not adequately represent the view that the other two bidders had much more expensive software and a more expensive support model. If you remove those elements the price differential is now 1.3 times higher and 1.5 times higher (if you remove contingency from the third bidder as the other two did not have it at all).

   While a thorough financial evaluation was completed, the OCIO acknowledges that better documentation could have been kept to demonstrate this evaluation. The OCIO commits to improving documentation around the financial component of RFP evaluations.

4. OCIO should ensure compliance with all terms and conditions of Procurement Agreements with vendors.

   The OCIO is in agreement with the Auditor General's recommendation and commits to ensuring improvements to the Statement of Work process. The OCIO has recently implemented a requirement to ensure that no resources start work until Statements of Work are approved, and a requirement for detailed backup for review and validation for all travel invoices.

   The OCIO notes that the Statement of Work is only one mechanism for managing costs. Other mechanisms include: a signed Vendor contract, the project plan, as well as monthly budget/project monitoring.

5. The Province should undertake thorough legal and financial assessments in instances where there may be potential breaches of the terms and conditions of legal agreements.

   The OCIO engaged the Department of Justice legal counsel to participate in discussions regarding contract cancellation. The Information Note clearly references that the Department of Justice solicitor was involved in the meeting where the vendor was advised that its approach did not meet the projects business requirements and drafted the cancellation letter to give effect to the contract termination.

   The OCIO commits to continuing to engage the Department of Justice in such matters.

APPENDIX

A

EXCERPTS FROM FEBRUARY 14, 2011 INFORMATION NOTE

EXCERPTS FROM FEBRUARY 14, 2011 INFORMATION NOTE

Title: Contract Issue with [the Vendor] on Integrated Case Management System Project

Issue: To advise on action being taken to cancel a $6.9 million contract with [the Vendor] for information technology professional services as a result of not meeting contractual obligations for the Integrated Case Management System

Background and Current Status:

- On September 4, 2008, the Government of Newfoundland and Labrador signed a devolved Labour Market Development Agreement (LMDA) [redacted] with the Government of Canada under which the primary responsibility for the design and delivery of labour market programs rests with Newfoundland and Labrador. A condition of the agreement is that the Province must have its own system solution in place by November 2012 to support the delivery of LMDA programs and services.

- On September 18, 2009, the OCIO, with Cabinet approval [redacted], issued a request for proposals to purchase, configure and implement a commercial off-the-shelf solution to meet the business requirements of the employment programs devolved to the provincial government from the federal government and the employment programs already being delivered by the provincial government (Career, Employment and Youth Services programs in the Department of Human Resources, Labour and Employment; Apprenticeship Program in the Department of Education). The solution must integrate with the provincial government's financial management system (Oracle FMS) and document management system (HP TRIM).

- [redacted] authorized the Office of the Chief Information Officer (OCIO) to negotiate and award a contract to [the Vendor] valued at $6.94 million, and Oracle Corporation Canada Inc., valued at $2.18 million, as part of the purchase and implementation of an integrated case management system for labour market programs at a total cost of $13.63 million ($9.1 million in vendor contracts and $4.5 million in departmental resources over two fiscal years – 2010-11 and 2011-12). Funding for the project is from three federal sources (100%) and budgeted in HRLE: IT subsidiary agreement to support devolution of LMDA programs; Labour Market Development Agreement and Labour Market Agreement.

- On August 5, 2010, OCIO and [the Vendor] signed an agreement to provide information technology professional services required to configure and implement the Siebel case management system purchased from Oracle Corporation in spring 2010.

- Early in the Planning Phase (fall 2010) with [the Vendor], considerable scope issues emerged, particularly integration with government's financial management system (FMS); replacement of functionality currently provided by the Accountability Resource Management System [redacted]

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[redacted] and replacement of the Apprenticeship Information Management System (Department of Education), as well as a number of other issues.

- In December 2010, following considerable effort to reach agreement on the scope issues throughout the fall, the project steering committee, comprised of senior representatives of OCIO, HRLE and Office of the Comptroller General (OCG), requested [the Vendor] to provide a summary of what the vendor would deliver within the bid amount without additional resources from GNL, and what it considers out of scope.

- In its summary provided on January 31, 2011, [the Vendor] advised that it cannot deliver on the scope of work for the costs identified in the contract [The Vendor] has advised that considerable functionality of the Siebel system that [the Vendor] included in its written bid and subsequently demonstrated in a week-long session in December 2009 is, in fact, no longer included by [the Vendor] within the scope of this project but, rather, is now defined by [the Vendor] as 'capability' of the system for potential future build.

- On February 1 and 2, 2011, GNL review teams, comprised of staff from OCIO, HRLE, OCG and Education (EDU), analyzed the contentious areas of the vendor's January 31st proposed approach and unanimously advised the Executive Sponsors that what was proposed does not meet the business requirements. The OCG and HRLE identified that the most egregious and essential aspect out of scope is a satisfactory approach to integrate the case management system with government's financial management system. [The Vendor] has identified significant additional resources that would be needed to do the work required to integrate with FMS, potentially in the range of 2,000 person-days, which OCIO estimates to be approximately $2 million. As well, though not yet fully specified, it appears that significant additional resources, in the range of millions of dollars, would be required to satisfy remaining scope issues.

- On February 4, 2011, the project's GNL Executive Sponsors (Executive Director, Solution Delivery, OCIO, and ADM, Corporate Services, HRLE) and legal counsel met with [the Vendor's] Executive Lead and Project Manager to advise that GNL had reviewed [the Vendor's] proposed approach. The approach that [the Vendor] proposed on January 31, 2011, does not meet the mandatory business requirements identified in the scope of work. OCIO advised [the Vendor] that government is now examining its options to go forward.

Action Being Taken:

- HRLE and OCIO, in consultation with Justice, anticipate terminating the contract through section 10.2, a sixty-day no-fault exit clause, by providing written notice to that effect to [the Vendor] on February 15, 2011.
- The work done to date on planning and design continues to be of value, regardless whether we continue with [the Vendor] or seek other professional services. Approximately $2.5 million of the $6.9 million [the Vendor] has been spent or is

anticipated to be spent on work done since the start of the project June 28, 2010, including outstanding invoices not yet submitted. During the sixty-day notice period, [the Vendor] and GNL project staff will continue to work on design (other than financial integration) and ensure that completed work is stored in TRIM, thereby preserving its value.

- The requirement continues for LMDA programs that were devolved to the Province to migrate from the federal system and to be supported by a provincial system. Oracle's Siebel software has been purchased and continues to be the desired product for HRLE. The Department of Education will need to determine if this software meets its business needs for the Apprenticeship Program.

- Considering that [the Vendor] appears unwilling to complete the scope of work within its bid and that the other two bids on this project were considerably higher than [the Vendor's], funding will be required in addition to the amount approved in [redacted]. HRLE is exploring the availability of additional funds through federal sources.

- HRLE will explore with the federal government an extension of the current CA-NL agreement to allow the use of the federal IT system to support the devolved programs beyond November 2012.

- OCIO will work with the business partners (HRLE, OCG and EDU) to assess options on how best to go forward to meet the case management and financial integration needs and receive the necessary approvals.

Date: February 14, 2011

PART 3.2

DEPARTMENT OF BUSINESS, TOURISM, CULTURE AND RURAL DEVELOPMENT

FINANCIAL ASSISTANCE TO BUSINESS

Summary

Introduction

The Province offers a significant number of programs that provide direct financial assistance to businesses. Direct financial assistance can be provided by way of Government grants, subsidies, loans, equity investments, and tax expenditures. Given that average expenditures are more than $100 million annually, it is important for Government to ensure that these programs are operating effectively.

Objective

The objective of our review was to determine whether procedures were in place for monitoring, evaluating and reporting on the effectiveness of Government financial assistance to business.

Scope

Our review covered the period from April 1, 2009 to December 31, 2014. Our review focused on the Departments of Business, Tourism, Culture, and Rural Development (BTCRD); Finance; Fisheries and Aquaculture; and Natural Resources, as those were identified as having significant expenditures related to financial assistance to business.

Our review included an examination of the programs, legislation, and policy and procedures applicable to Government financial assistance to business. It included determining which businesses received financial assistance, the amount of financial assistance received, and the review of procedures for monitoring, evaluating and reporting on related programs. Our review also included interviews with officials responsible for the program areas identified. We completed our review in February 2015.

Conclusion

For the 14 programs reviewed, departments could not always demonstrate that they were monitoring, evaluating, and reporting on the effectiveness of Government financial assistance to business.

Findings

Monitoring and Evaluation

1. Each of the 14 programs we reviewed had established and documented goals.

2. Seven of the 14 programs we reviewed, did not have documented objectives. The absence of program objectives would make it difficult to determine whether the overall goals of the program have been met.

3. All programs reviewed have processes in place to ensure that financial assistance is provided under the terms of Departmental programs.

4. All programs reviewed had procedures in place to take corrective action when businesses were not adhering to program requirements.

5. Of the 14 programs we reviewed, 10 programs did not have performance measures in place to assess program goals and objectives.

6. Of the 14 programs reviewed, 10 programs were not evaluated on a regular basis and did not have procedures in place to evaluate overall effectiveness to determine whether action should be taken.

Reporting

7. Of the 14 programs reviewed, departments had not set objectives with related performance measures for 10 programs and therefore, it was not possible for them to report on the performance of those programs.

Recommendations

1. Departments should set performance targets for all Government financial assistance to Business programs and monitor and evaluate their effectiveness.

2. Where programs are not meeting performance targets, the department responsible should address whether program changes are required.

3. Departments should report on program performance and this information should be periodically reported to the House of Assembly.

Objective and Scope

Objective

The objective of our review was to determine whether procedures were in place for monitoring, evaluating and reporting on the effectiveness of Government financial assistance to business.

Scope

Our review covered the period from April 1, 2009 to December 31, 2014. Our review focused on the Departments of Business, Tourism, Culture, and Rural Development (BTCRD); Finance; Fisheries and Aquaculture; and Natural Resources, as those were identified as having significant expenditures related to financial assistance to business.

Our review included an examination of the programs, legislation, and policy and procedures applicable to Government financial assistance to business. It included determining which businesses received financial assistance, the amount of financial assistance received, and the review of procedures for monitoring, evaluating and reporting on related programs. While we reviewed processes in place, it should be noted that we did not perform detailed compliance testing to ensure that the processes were always complied with. Our review also included interviews with officials responsible for the program areas identified. We completed our review in February 2015.

Background

The Province offers a significant number of programs that provide direct financial assistance to businesses. Direct financial assistance can be provided by way of Government grants, subsidies, loans, equity investments, and tax expenditures.

Included in this review of financial assistance to business are 14 Government programs under the Departments of:

- Business, Tourism, Culture, and Rural Development (BTCRD);
- Finance;
- Fisheries and Aquaculture; and
- Natural Resources.

Department of Business, Tourism, Culture, and Rural Development

Effective April 1, 2013, the then Department of Industry, Business and Rural Development consolidated 14 existing specific purpose commercial funding programs into a single Business Investment Fund. The Business Investment Fund has three main program areas providing financial assistance to businesses. These are:

- The Business Investment Program, administered through the Business Investment Corporation, which provides term loans and equity investments to small and medium sized enterprises (SME);

- The Business Development Support Program, administered through the Business Investment Corporation, which provides grants to qualified businesses up to 50% of eligible program costs; and

- The Investment Attraction Program (former Business Attraction Fund), which provides funding to eligible out-of-Province businesses, expanding or investing in the Province, in the form of term loans, forgivable loans, conditionally-repayable loans, or equity.

Three existing program areas for business remained. They were:

- The Economic Diversification and Growth Enterprises program (EDGE), which is a rebate program for taxes paid (in conjunction with the Department of Finance);

- Contact Centres, which is a wage subsidy program that, while continuing to honour existing obligations, has no funding allocated for new centres; and

- Aerospace and Defence Development Fund (ADDF) which expired at March 31, 2014.

As the ADDF and Contact Centre programs are not providing assistance to new clients, we did not include them in our review. The four other programs were included in our review.

Department of Finance

The Department is responsible for providing tax credits, incentives and benefit programs directly to businesses including the:

- Manufacturing and processing profits tax credit;
- Small business tax credit;
- Film and video tax credit (in conjunction with Newfoundland and Labrador Film Development Corporation);
- Scientific research and experimental development tax credit; and
- EDGE program remissions (in conjunction with BTCRD).

These five programs were included in our review, including the EDGE program which was also identified under BTCRD.

Fisheries and Aquaculture

The Department provided financial assistance to businesses through related program areas including:

- Fisheries Technology and New Opportunities Program, which focuses on research and development projects with a maximum contribution of $100,000 per project; and
- The Aquaculture Capital Equity Fund, which provides an equity investment in Corporations meeting specific eligibility criteria. The minimum investment by Government for finfish and shellfish operations is $250,000 and $100,000 respectively.

These two programs were included in our review.

Natural Resources

The Department provided financial assistance to businesses in the following program area:

- The Junior Exploration Assistance Program, which provides a non-repayable grant to qualifying junior mineral exploration companies of 50% of approved eligible costs to a maximum of $100,000 for Newfoundland exploration and $150,000 for Labrador exploration;

This program was included in our review.

Forestry and Agrifoods Agency

The Agency provided financial assistance to businesses through program areas including:

- The Growing Forward Program, which was a Federal/Provincial cost shared agriculture initiative that specified related program areas to be implemented within the Province. Applicants were eligible for a grant of up to $500,000 subject to program demand and availability of program funds. Growing Forward has since been replaced by Growing Forward 2 which provides grants of up to $400,000 per commercial applicant;

- The Agriculture and Agrifoods Development Fund, which encourages large scale investments in the industry. Applicants can receive up to 50% of total eligible project costs in the form of a grant;

- The Provincial Agrifoods Assistance Program (Agriculture Initiatives) provides financial assistance to eligible applicants involved in primary or secondary processing agriculture activities. Applicants can receive up to 50% of total eligible project costs in the form of a grant;

- The Canada-Newfoundland and Labrador Agriculture Research Initiative, which was a three year cost-shared program that provided for a grant of up to a maximum of $500,000 for eligible research costs. This program expired in 2013-14 and has now been replaced by the Provincial only program known as the Provincial Agricultural Research and Development Program;

- The Cranberry Industry Development Program, which was a five year program established in 2008 to facilitate cranberry site development. The program, which provided grants to applicants of $15,000 per acre up to a maximum of $150,000 per year, is now complete. On September 10, 2014 a new Federal/Provincial development program was announced to assist the industry. This program funds up to $30,000 per acre to eligible cranberry farmers; and

- The Forestry Industry Diversification Program was established in 2008 to assist the forest industry to compete in the global economy and to identify and develop specific new products and market opportunities. Loans, advances and investments under the program from 2010 to 2012 totaled approximately $15 million.

The Provincial Agrifoods Assistance Program was not selected for this review. As the Cranberry Industry Development Program is now complete, we did not include it in our review. As well, as there were no significant loans issued under the Forestry Industry Diversification Program since 2012, we did not include this program in our review. The three other programs were included in our review.

Table 1 contains direct financial assistance expenditures to businesses identified during the review. For the five year period April 1, 2009 to March 31, 2014, we identified 17 Departmental areas and/or activities having expenditures over that period in excess of $500 million, an average of more than $100 million annually.

Table 1

Financial Assistance to Business
Years ended March
($ millions)

Program Description	2010	2011	2012	2013	2014	Total
Department of Finance						
EDGE Remissions	0.9	0.6	0.7	0.4	1.0	3.6
Film and Video Industry Tax Credit	3.0	5.5	4.0	3.3	6.0	21.8
Manufacturing and Processing Profits Tax Rate Reduction	4.5	4.6	6.5	8.1	8.8	32.5
Research and Development Tax Credit	18.9	7.8	7.4	10.6	11.6	56.3
Small Business Tax Rate Reduction	31.6	42.1	64.0	63.1	61.1	261.9
Department total	**58.9**	**60.6**	**82.6**	**85.5**	**88.5**	**376.1**
Department of Business, Tourism, Culture and Rural Development						
Trade and Export Development (includes ADDF) - Grants and subsidies	0.8	1.0	0.6	0.4	1.7	4.5
Business Attraction Fund - Loans	1.4	1.1	0.4	0.3	1.9	5.1
Business Analysis (includes Contact Centres program)	2.3	1.7	2.2	0.4	0.6	6.3
Business Development Support Program (BIC) - Grants	0.7	0.6	0.8	0.8	2.1	5.0
Business Investment Program (BIC) -Loans and equity investments	3.5	2.9	3.4	1.4	4.3	15.5
Department total	**8.7**	**7.3**	**7.4**	**3.3**	**10.6**	**37.3**
Department of Natural Resources						
Forest Industry Diversification - Loans, advances, and investments	9.0	3.8	2.1	0.1	0.1	15.1
Agriculture Initiatives - Grants and subsidies	2.0	2.1	2.1	2.1	2.0	10.3
Department of Natural Resources (cont.)						
Agriculture and Agrifoods Development Fund - Grants and subsidies	1.4	2.0	3.2	1.5	1.6	9.7
Growing Forward Framework - Grants	4.9	6.0	6.2	4.8	5.6	27.5
Mineral Development (includes JEAP) - Grants and subsidies	2.5	2.8	2.9	2.0	1.8	12.0
Department total	**19.8**	**16.7**	**16.5**	**10.5**	**11.1**	**74.6**
Department of Fisheries and Aquaculture						
Fisheries Innovation and Development - Grants	1.8	3.1	2.2	3.6	2.8	13.5
Aquaculture Capital Equity Investment	1.0	3.8	8.0	1.8	1.0	15.6
Department total	**2.8**	**6.9**	**10.2**	**5.4**	**3.8**	**29.1**
Overall Total	**90.2**	**91.5**	**116.7**	**104.7**	**114.0**	**517.1**

Sources: Departmental Statements of Revenue and Expenditure
Budget Estimates (tax expenditures)
Business Investment Corporation (BIC) Financial Statements

Legislation

The programs delivering Government's financial assistance to business are governed by various legislation including**:**

- *Business Investment Corporation Act*;
- *Economic Diversification and Growth Enterprises Act*;
- *Industrial Development Corporation Act*;
- *Income Tax Act, 2000 and Regulations*;
- *The Loan and Guarantee Act, 1957*; and
- *Financial Administration Act*.

Detailed Observations

Monitoring, Evaluation and Reporting Effectiveness

The objective of our review was to determine whether procedures were in place for monitoring, evaluating and reporting on the effectiveness of Government financial assistance to business.

Conclusion

For the 14 programs reviewed, departments could not always demonstrate that they were monitoring, evaluating, and reporting on the effectiveness of Government financial assistance to business.

We identified findings in the following areas:

A. Monitoring and Evaluation
B. Reporting

1A. Monitoring and Evaluation

Overview

We expected that each program reviewed would have processes in place to monitor and evaluate the effectiveness of the financial assistance provided to businesses. This would include documented goals and objectives, processes to ensure that financial assistance was provided under the program requirements, a performance measurement system that measured performance against goals and objectives, periodic evaluations of these performance targets, and corrective action if monitoring results were not satisfactory. This would include consideration of whether the program should be altered, and/or whether it should be discontinued.

We reviewed the 14 programs selected to determine whether they met these expectations. We identified findings in the following areas:

i) Goals and objectives
ii) Compliance with program requirements
iii) Measurement systems and performance targets
iv) Periodic evaluations

The results of our review by department are provided in Table 2.

Table 2

Program Monitoring and Evaluation Results

Criteria	Department				
			Natural Resources		
	Finance	BTCRD	Mines and Energy branch	Forestry and Agrifoods Agency	Fisheries and Aquaculture
1A(i). Goals and objectives- Departments have documented goals and objectives for the various funding programs. - Goals - Objectives	 Yes No	 Yes Yes	 Yes No	 Yes Yes	 Yes Partially
1A(ii). Compliance with program requirements- Departments have processes in place to ensure that financial assistance is provided under the terms of Departmental programs and corrective action is taken when programs are not complying with program requirements.	Yes	Yes	Yes	Yes	Yes
1A(iii). Measurement systems and performance targets- Departments had measurement systems in place that included specific performance targets which identify outcomes achieved and negative outcomes addressed.	No	No	No	Yes	Partially
1A(iv). Periodic Evaluations- Departments performed periodic evaluations of program results	No	No	No	Yes	Partially

1A(i). Goals and Objectives

Introduction

Goals represent a long term purpose that is directed at the desired end result. Objectives should be more specific. They should be targeted results, which are measureable and tangible, which would help a program obtain their overall goals. Without objectives, it is difficult to determine whether overall goals are being met. Our review indicated the following:

Documented Goals

We reviewed documentation of the purpose of all 14 programs. We found that all programs did have a set purpose, and therefore they did have documented goals.

Documented Objectives

We reviewed the documentation of objectives that departments were able to provide for all programs. We found that, although programs had a set purpose, 7 of the 14 programs did not have measurable, tangible objectives specific to the overall program goal. We found that the following programs did have established objectives at the program level that would facilitate performance measurement:

- the Growing Forward Program, Agriculture Research Initiative, and Agriculture and Agrifood Development Fund, administered through the Forestry and Agrifoods Agency;
- the Business Investment Program, Business Development Support Program, and the Investment Attraction Program of the Department of BTCRD; and
- the Fisheries Technology and New Opportunities Program administered through the Department of Fisheries and Aquaculture.

Findings

1. Each of the 14 programs we reviewed had established and documented goals.
2. Seven of the 14 programs we reviewed did not have documented objectives. The absence of program objectives would make it difficult to determine whether the overall goals of the program have been met.

1A(ii). Compliance with Program Requirements

Introduction

All programs should have processes in place to ensure that they are providing financial assistance to business in accordance with the requirements of their respective programs. Depending on the program size and resources, this process may include staff who are responsible for documenting the evaluation of eligibility, and for providing an overall recommendation for approval/rejection. These eligibility requirements are specific to the program and should support the overall goal and objectives of that program.

When businesses are not adhering to program requirements, corrective action should be taken. This may mean withholding future funding, or requiring businesses to repay funding already received.

Our review indicated the following:

Eligibility Requirements

The Federal Government administers certain tax expenditure programs on behalf of the Province. For these programs we obtained the agreement, which required that there were processes in place for determining eligibility requirements. For the other programs, we obtained documentation of the eligibility requirements, documentation that these requirements were being considered, and documentation that recommendations were being made, prior to financial assistance being provided.

Processes were in place for all 14 programs to ensure compliance with program requirements, as well as tracking program expenditure activity, and comparison to estimates.

Corrective Action

We were able to determine through discussions with program officials and a review of program documentation, that there are processes in place for the 14 programs, which would result in corrective action if programs were not complying with their program requirements.

Findings

3. All programs reviewed had processes in place to ensure that financial assistance is provided in accordance with the terms of Departmental programs.

4. All programs reviewed had procedures in place to take corrective action when businesses were not adhering to program requirements.

1A(iii). Measurement Systems and Performance Targets

Introduction

Departments should assess whether funded programs are meeting their goals and objectives. This should include a measurement system that would act as the foundation for measuring achievement of these goals and objectives, including milestones that measure progress of quantifiable objectives, and comparing the actual outcomes to targeted outcomes. These targets should be specific to the program, and could include financial and/or non-financial measures. Examples could include:

- Jobs created
- Jobs maintained
- Cost per job
- Program uptake
- Return achieved

Once specific objectives have been assessed, consideration should be given to whether programs are meeting their overall goals. This could help assess whether the program was providing long-term, sustained, value to the Province.

Assessment of Goals and Objectives

During our review of whether goals and objectives were in place, we found that 10 of the 14 programs reviewed did not have performance measurement systems to measure progress against documented goals and objectives. These 10 programs may have established goals and objectives which they have considered, however, they did not have measureable targets. Therefore, there is no basis to assess whether the results are satisfactory. For example, the Business Investment Corporation has an objective to provide funding toward the start-up of and growth of small and medium sized businesses, and one of the indicators is the number of applicants approved for each program. However, they have not set targeted numbers for this indicator, and therefore the success of the actual outcome cannot be assessed. For these programs, although they may be considering the goals of the program, we do not believe that this assessment would be sufficient given that there are no targets to conclude against to support the assessment.

The four programs that did have documentation to support that they were assessing goals and objectives using a performance measurement system, including measurable targets, were the Growing Forward Program, Agriculture Research Initiatives, and Agriculture and Agrifood Development Fund, administered through the Forestry and Agrifoods Agency, and the Fisheries Technology and New Opportunities Program, administered through the Department of Fisheries and Aquaculture.

Finding

5. Of the 14 programs we reviewed, 10 programs did not have performance measures in place to assess program goals and objectives.

1A (iv). Periodic Evaluations

Introduction

Program results should be evaluated on a regular basis to ensure the program is meeting the intended goal. We would expect to see procedures in place that would facilitate these evaluations. This would include looking at any performance measures that programs have in place that would aid in meeting goals and objectives. Based on these evaluations, we would expect that departments would have processes in place to determine whether action should be taken when programs are not meeting their goals, including consideration of whether a program should continue.

Evaluation Process

We reviewed the 14 programs and found that 10 did not have procedures in place to facilitate regular evaluations, and therefore would not be able to determine whether corrective action should be taken. Evaluation procedures were in place for 4 of the 14 programs. These included the Growing Forward Program, Agriculture Research Initiative, and Agriculture and Agrifood Development Fund, administered through the Forestry and Agrifoods Agency, and the Fisheries Technology and New Opportunities Program administered through the Department of Fisheries and Aquaculture.

The Department of BTCRD has commenced the implementation of an accountability framework to support the monitoring of the Business Investment Fund, however, it could not demonstrate that a full scale evaluation had been performed or that it would facilitate a full evaluation of the Program. Department officials indicated that the framework was still in the early stages of implementation and that a process evaluation was planned for two years after the 2013 implementation of the new fund. Information provided by the Department did not include target levels for each output and outcome indicator identified.

There were also two reports identified, prepared on an ad hoc basis, that assessed the impact of programs/Government supported industry on the provincial economy. They included:

- An internal review, dated December 2013. The review was performed by the Project Analysis Division of the Department of Finance on the economic impact of productions accessing the NL Film and Video Tax Credit for fiscal years 2009-10 to 2012-13.

- The Department of Fisheries and Aquaculture partnered with the Economic Research and Analysis Division of the Department of Finance, to complete an economic impact analysis of the provincial aquaculture industry that was released to the public in January 2015.

These reports, while providing information on the impact of programs on the Provincial economy, did not evaluate program results against a set of established objectives. Consequently, they did not provide a basis to evaluate the overall performance of the programs.

Finding

6. Of the 14 programs reviewed, 10 programs were not evaluated on a regular basis and did not have procedures in place to evaluate overall effectiveness to determine whether action should be taken.

1B. Reporting

Overview

We expected that each program would be reporting on the effectiveness of Government financial assistance to business and that this information would be presented to the House of Assembly on a periodic basis.

We reviewed the 14 programs selected to determine whether they met this expectation. We identified findings in the following area:

i) Reporting results of evaluations

The results of our review by department are contained in Table 4.

Table 4

Program Reporting on Performance

Criteria	Department				
	Finance	BTCRD	Natural Resources		Fisheries and Aquaculture
			Mines and Energy branch	Forestry and Agrifoods Agency	
1B (i). Reporting the results of evaluations- Departments report on program effectiveness	No	No	No	Yes	Partially

Introduction

Departments should be reporting the results of program performance evaluations. This can be done through program reports which show the measurement of actual outcomes compared to targeted outcomes. If objectives and performance measures are not in place, it will not be possible for departments to report on performance, as there will be nothing in place to measure progress against.

Reporting Results of Evaluations

As departments were not able to demonstrate that they were evaluating performance (and lacked documented objectives and performance measures) for 10 of the 14 programs reviewed, it was not possible for them to objectively report on performance. Only the Forestry and Agrifoods Agency, for three of its agriculture related programs, and the Department of Fisheries and Aquaculture for one of its programs, could demonstrate that they were reporting on performance against objectives or targets. These included:

- Annual performance reports for the Federal-Provincial cost-shared Growing Forward program. These reports included targets, results against targets and commentary on the results;

- A report prepared on the results of the Canada-Newfoundland and Labrador Agriculture Initiative 2011-2014 which evaluated the objectives of the program against measurable outcomes;

- A March 2013 report on the Agriculture and Agrifoods Development Fund, which reviewed whether program objectives were met on a series of projects completed from 2006-07 to 2011-12; and

- An October 2013 report prepared by an independent consultant on the Fisheries Technology and New Opportunities Program which evaluated the program objectives, program operations, and program strengths and weaknesses for the period from September 2010 to June 2013.

Finding

7. Of the 14 programs reviewed, departments had not set objectives with related performance measures for 10 programs and therefore, it was not possible for them to report on the performance of those programs.

Recommendations

1. Departments should set performance targets for all Government financial assistance to Business programs and monitor and evaluate their effectiveness.

2. Where programs are not meeting performance targets, the department responsible should address whether program changes are required.

3. Departments should report on program performance and this information should be periodically reported to the House of Assembly.

Department of Business, Tourism, Culture and Rural Development Response

The Department of Business, Tourism, Culture and Rural Development (BTCRD) has reviewed the draft audit report entitled "Financial Supports to Business by Government" for the period 2009-2014. Specifically, this letter is in response to the review of the Business Investment Fund (which is made up of the Business Investment Program - Loans, the Business Development Support Program (BIC) - Grants, the Investment Attraction Program - Loans and equity investments) and the Economic Diversification and Growth Enterprises Program (EDGE) - rebate program for taxes paid (in conjunction with the Department of Finance).

I thank your office for its input and comments regarding the above programs, which as the report notes, all have well established and documented goals, have processes in place to ensure that all financial assistance is provided in accordance with the terms of programs, and have procedures in place to take corrective actions necessary when businesses do not adhere to the program requirements.

As audit report notes, the Department consolidated 14 existing programs into a single program, Business Investment Fund, just two years ago. The accountability framework and evaluation plan for the program (developed in 2013) has evaluation processes beginning 24 months after the program's creation, and a full scale evaluation during year four to five. Department officials provided a significant amount of material related to our financial statements, and the monitoring and evaluation processes for the Business Investment Fund; as well as the predecessor business program, Small and Medium Enterprise Fund (SMEF) including the significant evaluation activity applied to this fund.

Officials also provided the accountability framework and logic model, which were developed during the design of the Business Investment Fund, to support the ongoing monitoring and evaluation of the Fund. These outline the objectives, activities, outputs and outcomes (immediate, intermediate, long term and ultimate). The measurement frameworks were produced through a consultative process involving BTCRD with key input from BTCRD Policy and Planning Division and the Executive Council's Program Evaluation Office. The Department decided to apply a continuous ***developmental evaluation approach***[1] *to the Fund. This evaluation approach allows data-based decision-making that improves the efficiency and effectiveness of the Fund, and is part of an overall evaluation of the continuum of business supports e.g. Regional Development Fund, Venture Capital, Business Attraction funds etc. The evaluation plan, outlines ongoing evaluation processes with a process evaluation to commence after 24 months of delivery. When contacted in February, the program had not reached that milestone, the initial evaluation is scheduled to begin in 2015-16 and the full scale evaluation is scheduled for 2017-18. All necessary outputs and outcomes are now fully incorporated into the department's robust information management system (CS3) and annual reporting.*

[1] Evaluation processes, including asking evaluative questions and applying evaluation logic, to support a program, product, staff and/or organizational development. The evaluator is part of a team whose members collaborate to conceptualize, design and test new approaches in a long-term, on-going process of continuous improvement, adaptation and intentional change. The evaluator's primary function in the team is to elucidate team discussions with evaluative questions, data and logic, and facilitate data-based decision-making in the developmental process (Michael Quinn Patton, CES, 2009).

As a business program delivered by Government, the Business Investment Fund is offered to a variety of sectors, which are all vastly different in need and opportunity regarding retention and growth, as well as regional strengths and capacity. Since, the Fund does not focus on one sector, but responds to market demand and is required to be responsive and flexible, specific target numbers haven't been assigned to the outputs. However, there are targets established at a branch work plan level to inform ongoing monitoring of the Business Investment Fund.

With less than two years of program delivery, many of the projects are open and active with ongoing monitoring of results and regularly updated Account Status Reports. The department uses a grade system based on four categories to monitor loans and equity investments. The category refers to the assigned category of a client account indicating the level of risk and potential repayment. The level of risk is not based on delinquency alone but on a host of factors including security and future direction of the enterprise. It also reflects the risk associated with the nature of the business or industry. A variety of reviews around the accounts are implemented at various staff levels, including monthly, quarterly and annually. It is during these assessments that successes or issues of the investment are captured. The Account Status Report information is captured and monitored in the CS3. These details will inform the full scale evaluation including all components of an enterprise.

Regular monitoring and evaluation processes are conducted by all staff, Directors, Management Committees and the BIC Board of Directors, including regular review of portfolio health. As well, the BTCRD Policy division uses the department's information management system to track investments and applicable indicators, with ongoing review of data using baseline information dating back to 2005.

While job creation is a consideration for some investments assessed under the Business Investment Fund, the Fund is not a job creation fund but rather, a fund to support business retention, development and growth. In fact, in some cases due to labour shortages or recruitment challenges, investments are made in innovative technology that may assist in ensuring business retention. It is worthy to note that earlier audits and annual reports clearly delineate outputs and outcomes that are not job related. While the ability to track jobs is included in the information management system, job creation is not a primary measure of success for the programs or indeed the mandate of the department. Other jurisdictions and federal agencies such as ACOA also recognize the validity of more comprehensive indicators with outcomes such as increased productivity and competitiveness.

Investment Attraction Fund (IAF) and EDGE

As with all BTCRD funding decisions, evaluation is critical to both Investment Attraction Fund (IAF) and EDGE approvals. Both components are guided by the Accountability Framework and Strategic Plan of the department and related objectives and indicators, with yearly measurement and reporting through the Annual Report. For these two programs, evaluation starts from the initial contact with the client and is built into all aspects of the client interaction from this point all the way through to client aftercare, including compliance monitoring and reporting. As funds are disbursed and through the compliance requirements outlined in the terms and conditions of approval, metrics such as sales, capital purchases, job creation and overall financial health are compared to the intended outcomes of the funding approval, as appropriate, to ensure that the funds are being disbursed and repaid as outlined in the original approval.

Reporting & Evaluation

BTCRD is heavily involved in the evaluation of its programs and services. All branches are involved in the development of accountability frameworks, logic models, evaluation plans, and setting objectives, indicators, measures to monitor the progress and performance of initiatives. The department uses the following methods to report annually to the public about investments.

- *Annual Report- Through an annual report, BTCRD reports on the Strategic Plan of the department and related objectives and indicators, with yearly measurement. The strategic plan is designed to ensure annual reporting of investments and types of business development supported.*

- *BIC Activity Plan Report - This annual report of the BIC Board has clearly defined objectives, measure and indicators to report on progress of funds.*

- *EDGE Activity Plan Report - This annual report also has defined objectives, measures and indicators to report on the EDGE applications.*

- *Evaluation Plan Report - evaluation activities are undertaken for the department's various programs and services, and reports on the output indicators for the funding programs are ongoing. The process evaluation and the outcome evaluation are to follow as per the timelines in the framework.*

In conclusion, the Business Investment Fund is still in the early stages of implementation and the department's evaluation plan identifies it as too early for the Department to administer a full-scale evaluation. However, preliminary evaluation will be undertaken this year and a full scale evaluation will be done in 2017-18. In the meantime, the department utilizes various tools for ongoing monitoring and evaluation to inform decisions and policy on a continuous basis. While specific target numbers have not been assigned to the various outputs, the Department applies a significant amount of due diligence to setting goals, objectives and targets; thorough assessments including economic benefit and impact analysis; project monitoring and evaluation; as well as overall Fund evaluation.

Department of Finance Response

Tax expenditures represent a substantial commitment and the Department of Finance would agree with the recommendation that government should set performance targets for tax expenditures and to monitor and evaluate their effectiveness. Measurable objectives are used as assessment tools to determine whether or not the tax expenditure is successful in achieving its intended goal. By linking the tax expenditure to a set of verifiable objectives, their efficacy becomes easier to evaluate. However, we would note that for some tax expenditure programs, establishing measurable objectives and measuring performance are not easily achieved given the amount of time that has passed since the introduction of some of the programs. For these, it is often not possible to isolate the impact of the program from the plethora of other factors acting on the economy.

Since 2014, the Department of Finance, in conjunction with the Policy, Innovation and Accountability Office (PIAO) has developed a Performance Measurement Plans for new tax expenditure programs. These plans provides a clear account of measurable objectives to be included as part of its transparency and accountability framework that help to determine whether tax expenditures are achieving their objectives, whether the benefits exceed costs and whether they continue to be necessary and relevant.

We would note that your draft review suggests that the Department of Finance does not conduct periodic evaluations of tax expenditure program results. However, the Department of Finance does conduct periodic global reviews of its programs as part of the annual budget process, as well as more focused reviews on an ad-hoc basis. When giving consideration to which programs are subject to review, the Department of Finance considers the amount of tax revenue foregone, whether unintended consequences have arisen as a result of the program, the elapsed time since the measure was last evaluated and finally, whether the tax expenditure in question is subject to sunset provisions. Given limited resources, only a handful of tax measures can be evaluated in detail in any given year.

Department of Fisheries and Aquaculture Response

The department agrees that financial assistance programs need to have clear goals and objectives, be properly managed and implemented, and be subject to periodic evaluation and reporting. In this context, the department appreciates the Auditor General's review and recommendations.

The department is pleased to note that the Fisheries Technology and New Opportunities Program was cited by the Auditor General as meeting expectations under all the review criteria. The department will continue its efforts to ensure this program is effective.

With respect to the Aquaculture Capital Equity Program, the department notes that this program has supported significant expansion of the aquaculture sector since its inception, resulting in major economic benefits. This has been well documented in a recently released report which was compiled in partnership with the Economic Research and Analysis Division of the Department of Finance. This report indicates that spurred by ACEP, expansion of aquaculture in the province has resulted in a four-fold increase in employment and ten-fold increase in GDP from this sector over the 2003 to 2013 period. In addition, the department accepts the Auditor General's recommendations that further effort be directed to clearly stating goals and objectives, and to periodic evaluation and reporting. In this regard, based on the Auditor General's previous (2014) report specifically focused on ACEP, the department has recently completed a new policy and procedures manual and accountability framework for ACEP, which will be instrumental to addressing the Auditor General's recommendations in both reports.

Forestry and Agrifoods Agency Response

It is the Agency's opinion that programs offered by the Agrifoods Development Branch are being delivered within a responsible context while exercising due diligence in the administration of the Growing Forward Program, Agriculture and Agrifoods Development Fund, and the Agriculture Research Initiative.

The Forestry and Agrifoods Agency agrees with the audit findings that the programs do meet expectations with regards to monitoring, evaluation and reporting effectiveness. With specific reference to the reports recommendations:

1. ***Departments should set performance targets for all Government financial assistance to Business programs and monitor and evaluate their effectiveness.***

   The report recognizes that the Agency has set these targets and are monitoring and evaluating their effectiveness. The Agency will continue to do this for all of our financial assistance programs.

2. ***Where programs are not meeting performance targets, the department responsible should address whether program changes are required.***

   The Agency agrees that, where regular monitoring indicates that performance targets are not being met, we will address whether program changes are required.

3. ***Departments should report on program performance and this information should be periodically reported to the House of Assembly.***

   The agency agrees that we will report on program performance and that this information will be periodically reported to the House of Assembly.

Department of Natural Resource Response

The department acknowledges the findings of the review and has begun implementation of the recommendations in the draft report. The Mineral Development Division is responsible for administration of the Junior Exploration Assistance Program and is working with Strategic Planning and Policy Coordination staff to complete a performance and evaluation framework for the program. The department will work towards reporting the results of the evaluation for fiscal year 2015-16.

PART 3.3

DEPARTMENT OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

TEACHER PROFESSIONAL DEVELOPMENT

Summary

Introduction

The vision of the Department of Education and Early Childhood Development (the Department) is of an educational community that fosters safe, caring and inclusive learning environments enabling individuals to reach their full potential. The Department Curriculum and Programs line of business indicates that the Department is responsible for providing professional development opportunities to teachers. For the 2013-14 school year there were 5,357 full time equivalent teachers employed by two districts teaching approximately 67,400 students in 264 schools.

Objectives

The objectives of our review were to determine whether:

1. professional development for teachers was properly planned;

2. professional development for teachers was properly implemented; and

3. professional development for teachers was properly monitored.

Scope

The responsibility for teacher professional development is shared between the Department of Education and Early Childhood Development (the Department), the Province's two school districts and individual schools. Our review included professional development activities of the Department, the Newfoundland and Labrador English School District (the District) and its schools, and covered the following periods:

Professional Development Expenditures

- Department April 1, 2012 to June 30, 2014
- District and schools September 1, 2013 to June 30, 2014

Professional Development Sessions

- Department April 1, 2013 to October 31, 2014
- District and schools September 1, 2013 to October 31, 2014

We reviewed documentation provided by the Department and the District related to the planning, implementation and monitoring of teacher professional development activities and examined a sample of 52 professional development sessions given to teachers. In addition, we selected a sample of 60 Department and District teacher professional development expenditures to review, however, we only examined 30 expenditure samples as information related to substitute costs and teacher leave forms was not provided. Samples were non-statistical and selected both randomly and judgmentally. We also interviewed officials at the Department and the District.

We completed our review in March 2015.

Conclusions

Objective 1

The Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District had planning processes in place for teacher professional development including the establishment of learning models, however, we identified issues with the establishment of effective professional development processes, the identification and selection of topics, and the development of overall and sessional goals.

Objective 2

The Department of Education and Early Childhood Development had developed a Professional Learning Model which was intended to be used for delivery of professional development related to new curriculum, however, the Newfoundland and Labrador English School District did not always implement professional development sessions in accordance with the Department Model or on a consistent basis across the District. While the District indicated it required flexibility in the delivery of professional development in order to respond to specific circumstances, there is a risk that the outcomes of the professional development sessions intended by the Department when the Learning Model was developed may not be achieved if the Model is not followed. The Model was not followed in a number of instances as a result of insufficient or inappropriate resources.

Schools did not always complete the required training or had the necessary resources to ensure the curriculum was properly delivered to students.

Objective 3

The Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District did not always:

- complete evaluations of professional development sessions;
- monitor teacher professional development to determine whether overall program and sessional objectives were met;
- record and monitor teacher attendance; and
- record and monitor teacher professional development expenditures.

Findings

Planning of Teacher Professional Development

Principles of Effective Teacher Professional Development

1. The Department developed and communicated to teachers a Professional Learning Model for new curriculum, which included characteristics for effective professional development.

2. The District developed a Professional Learning Close-out Model for 2014-15. The District indicated that the Model was established based upon principles of effective professional learning, however, there was no documentation that these principles were incorporated into the development of the Model or that these principles were communicated to teachers.

Identification and Selection of Professional Development Topics

3. The Department had no documented process in place to identify, prioritize, and select topics for non-curriculum based professional development initiatives other than initiatives identified by Government directive or in its strategic plan.

4. The District had processes in place to identify, prioritize, and select topics for professional development.

Establishment of Overall and Sessional Goals

5. For the professional development sessions sampled, predetermined goals were established but there were differences among the four regions on how specific the goals were and on how they were communicated to staff.

6. Overall goals for teacher professional development were established by the Department, however, the Department and the District did not have specific targets or outcomes from student learning.

Implementation of Teacher Professional Development

7. None of the three professional development sessions directed at new curriculum that we sampled were implemented in accordance with the Department Professional Learning Model. The District indicated that it was not required to follow the established Department Model and that it required flexibility in the delivery of professional development in order to respond to specific circumstances.

8. The Department Professional Learning Model for new curriculum was not followed due to various resource and scheduling issues. For example, materials were not ready, facilitators were not available until the Fall, training for program specialists and lead teachers was provided in May thereby not allowing enough time for Spring sessions, and three regions indicated that the Fall was more effective as teacher assignments were not completed until then and costs would be reduced.

9. Three schools did not receive the required professional development training for one new curriculum professional development topic included in our sample. One region reported that two schools did not complete any of the three components and another school in the region did not complete components 1 and 2 of the Visual Arts training session.

10. Schools did not always have the proper resources for one new curriculum included in our sample, before the curriculum was taught to students. For example, 27 schools in three regions reported software was not installed, not functioning properly or more computers were needed.

11. The District had scheduled three professional development days each year as required by the teacher collective agreements.

12. Some schools did not provide five close-out school days as provided by the District Professional Learning Close-out Model as a result of weather cancellations and additional close out days were not scheduled.

13. The District Professional Learning Close-out Model scheduled one of the five close-out days to be used for curriculum training, however, one of the four regions professional development sessions for curriculum were not incorporated into its close-out days. As a result, the District Model was not consistently applied to all regions.

Monitoring of Teacher Professional Development

Evaluation of Teacher Professional Development Sessions

14. The roles of the Department and the District in the evaluation process lacked clarity as District staff indicated that the analysis and results of the evaluations for four of the 12 curriculum sessions that we sampled were being carried out by the Department, even though the Department indicated that the evaluation for curriculum sessions was a District responsibility.

15. For the two Department non-curriculum sessions we reviewed, the Department analyzed teacher evaluations and planned to evaluate the two programs once the programs were fully implemented.

16. The District did not have documented policies and procedures for the evaluation of the effectiveness of professional development sessions to ensure sufficient information was gathered during the evaluation process to determine whether the professional development was effective, that evaluations were always completed, and the results were analyzed and reported.

17. For our sample, the District did not always complete evaluations or analyze and report the evaluation results for professional development sessions.

18. The District indicated that it carried out informal evaluation and feedback throughout the year but due to the nature of the activities, there was no supporting documentation.

Monitoring of Overall Teacher Professional Development Activities

19. There was no system in place to track the professional development training that each teacher received.

20. The Department did not monitor and report on the effectiveness of overall teacher professional development to maintain a highly qualified workforce. The Department did not monitor whether all teachers received the required training or the impact of professional development on student achievement.

21. While the District had processes in place to monitor teacher professional development at the school level, there was no assessment on the effectiveness of overall professional development.

Monitoring and Follow-up of Attendance

22. The Department and the District did not have a policy to monitor attendance and provide follow-up training.

23. The District did not have consistent practices across each of its four regions for recording attendance at professional development sessions.

24. For our sample, the Department and the District did not always record and monitor attendance for professional development sessions.

25. For our sample, teachers did not always attend sessions and follow-up training was not always provided.

Monitoring of Teacher Professional Development Expenditures

26. Expenditures of approximately $3.3 million for the year ended March 31, 2013 and $3.0 million for the year ended March 31, 2014 were reported by the Department as teacher professional development even though the expenditures were not for teacher professional development. As a result, variances and funding gaps for teacher professional development and other expenditures may not be readily apparent.

27. The District could not provide leave forms for a sample of 30 teachers as requested. As a result, we could not confirm that the substitute costs recorded by the Department were for a teacher to attend a professional development session or whether the request was properly approved in advance.

28. The District did not determine whether there were sufficient discretionary leave days available to meet the needs of teacher professional development.

Recommendations

1. The Department and District should consider reviewing and revising their professional learning models to include the characteristics of effective professional development and agree on the best models to consistently implement professional development across the District.

2. Overall professional development and individual session goals should be specific and communicated consistently across all regions of the District, with established targets linked back to student outcomes, where possible.

3. The District should provide professional development to teachers in accordance with established learning models.

4. The District, in consultation with the Department, should establish a professional development policy on the recording and monitoring of attendance, and the training of absent teachers.

5. The District, in consultation with the Department, should establish a policy on evaluation processes to be used to evaluate the quality and effectiveness of professional development sessions.

6. The District, in consultation with the Department, should maintain an information system to record professional development sessions and teacher training.

7. The Department and District should monitor and report on the overall effectiveness of teacher professional development towards maintaining a highly qualified workforce and achieving desired student outcomes.

8. The Department should ensure expenditures recorded to the teacher professional development activity code are legitimate professional development expenses.

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

1. professional development for teachers was properly planned;

2. professional development for teachers was properly implemented; and

3. professional development for teachers was properly monitored.

Scope

The responsibility for teacher professional development is shared between the Department of Education and Early Childhood Development (the Department), the Province's two school districts and individual schools. Our review included professional development activities of the Department, the Newfoundland and Labrador English School District (the District) and its schools, and covered the following periods:

Professional Development Expenditures

- Department April 1, 2012 to June 30, 2014
- District and schools September 1, 2013 to June 30, 2014

Professional Development Sessions

- Department April 1, 2013 to October 31, 2014
- District and schools September 1, 2013 to October 31, 2014

We reviewed documentation provided by the Department and the District related to the planning, implementation and monitoring of teacher professional development activities and examined a sample of 52 professional development sessions given to teachers. In addition, we selected a sample of 60 Department and District teacher professional development expenditures to review, however, we only examined 30 expenditure samples as information related to substitute costs and teacher leave forms was not provided. Samples were non-statistical and selected both randomly and judgmentally. We also interviewed officials at the Department and the District.

We completed our review in March 2015.

Background

The vision of the Department is of an educational community that fosters safe, caring and inclusive learning environments enabling individuals to reach their full potential. The Department mandate is to be responsible for select outcomes with respect to early childhood learning and all aspects of K-12 education in Newfoundland and Labrador. The Department has eight lines of business, one of which is "Curriculum and Programs". This line of business includes professional development opportunities for teachers. Teacher professional development is intended to maintain a highly qualified workforce to effectively deliver programs in a changing educational environment.

Effective September 1, 2013, the former five schools districts were reduced to two school districts; the District and the Conseil Scolaire Francophone Provincial de Terre-Neuve-et-Labrador. For the 2013-14 school year there were 5,357 full time equivalent teachers employed by the two Districts teaching approximately 67,400 students in 264 schools.

The *School Act, 1997* (the *Act*) defines the responsibility for professional development. Section 117 of the *Act* provides that the Minister may issue policy directives with respect to the professional development of teachers and employees of the Districts. Section 80 of the *Act* also requires the Districts to develop and implement a program of in-service training for its employees. The Provincial Collective Agreement and the Labrador West Collective Agreement for teachers require three professional development days to be scheduled by the District each year. The collective agreements also provided for additional in-service time to be assigned and approved at the District's discretion.

Table 1 provides a summary of the Department teacher professional development expenditures.

Table 1

Department of Education and Early Childhood Development
Teacher Professional Development
Department Expenditures
For the Years Ended March 31

Department Expenditures	Actual 2012	Actual 2013	Actual 2014	Budget 2015
Allowances and assistance	$5,210,287	$5,045,842	$4,791,916	$4,893,500
Grants and subsidies	4,592,715	3,613,144	3,113,469	3,135,000
Total	**$9,803,002**	**$8,658,986**	**$7,905,385**	**$8,028,500**

Source: Province of Newfoundland and Labrador Public Accounts and 2015 Estimates

The Department allocated between $7.9 and $9.8 million annually since 2012 for teacher professional development. The Department provided funding through allowances and assistance for education leave and for substitute teachers related to professional development activities. The Department provided funding through grants and subsidies for teacher development activities such as new curriculum, school supports, school safety and student achievement initiatives.

Detailed Observations

1. Planning of Teacher Professional Development

Objective

To determine whether professional development for teachers was properly planned.

Conclusion

The Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District had planning processes in place for teacher professional development including the establishment of learning models, however, we identified issues with the establishment of effective professional development processes, the identification and selection of topics, and the development of overall and sessional goals.

Our review considered whether:

- Principles for teacher professional development, which included characteristics for effective professional development, were established and communicated to teachers;
- Professional development topics were identified, prioritized and selected based upon predetermined criteria; and
- Predetermined goals for overall teacher professional development and individual professional development sessions were developed.

1A. Principles of Effective Teacher Professional Development

Introduction

Best practices identified seven principles of effective teacher professional learning which should be incorporated into professional learning. Effective professional learning should be:

- focused on student outcomes and student learning and not just the needs of teachers;
- school based and included in the day-to-day work of teaching;
- based on the best research as to what is effective learning and teaching;
- collaborative and include reflection and feedback;
- evidence based and include data from both formative and summative evaluations;
- ongoing, supported and fully integrated; and
- both an individual and a collective responsibility between all levels of the education system.

Both the Department and the District had developed professional learning models. The Department developed a Professional Learning Model for new curriculum implementation and the District developed a Professional Learning Close-Out Model for both curriculum and non-curriculum professional development.

Department Professional Learning Model

The Department implemented a Professional Learning Model for new curriculum in September 2009 that included the seven principles of effective learning. The Department Model, including a summary of attributes and characteristics, was posted on the Department website. The Department Model recommended professional learning to be provided through three components:

Component 1 - a ½ day session in May or June in the school year before course implementation and completed individually or in small groups. It included a review of an on-line multimedia package containing an overview of the new curriculum, curriculum guide, and resources with teachers encouraged to reflect on the content.

Component 2 - a ½ day session in May or June, following time for reflection of Component 1, and completed in groups of two to 10 teachers, either virtually or face-to-face. It included an opportunity for reflection, inquiry, and discussion of the information included in Component 1 and to work through exploratory activities.

Component 3 - a one day session in early Fall of the school year of implementation and completed in large group, face-to-face, sessions. It included a focus on teaching and learning within the subject area and incorporated suggestions provided by teachers in Component 2.

The District indicated that it was responsible for implementing teacher professional development and it was not required to follow the established Department Model, as this was a recommended approach for delivering new curriculum training, and not a requirement.

Finding

1. The Department developed and communicated to teachers a Professional Learning Model for new curriculum, which included characteristics for effective professional development.

District Professional Learning Close-Out Model

For the 2013-14 school year, the first after the consolidation of the school districts, the District continued to follow the practices for the former four districts at each of the regions. In September 2014, the District implemented a model for 2014-15 to be used in all four regions. The District Professional Learning Close-out Model provided information on the structure and responsibility for each professional development day. The District Model provided for five close-out days which included one day for new curriculum, two days for school development and two days for District priorities. Close-out days are days in which schools are closed so that all teachers can be provided with professional learning.

In addition to the five close-out days, professional development days were available for teachers to attend additional sessions which focused on individual or group priorities. These sessions required the provision of substitute teacher time.

The District indicated that the Model was established based upon principles of effective professional learning, however, there was no documentation that these principles were incorporated into the development of the Model or that they were communicated to teachers.

Finding

2. The District developed a Professional Learning Close-out Model for 2014-15. The District indicated that the Model was established based upon principles of effective professional learning, however, there was no documentation that these principles were incorporated into the development of the Model or that these principles were communicated to teachers.

1B. Identification and Selection of Professional Development Topics

Introduction

Best practices recommends that professional development topics should be identified, prioritized and selected based upon predetermined criteria. The Department was responsible for new curriculum implementation as well as other Department initiatives for non-curriculum topics. The District was responsible for school-based professional development and District priorities.

Department Process

Curriculum Professional Development

Teacher professional development for curriculum is required to be provided when new curriculum is introduced by the Department. In December 2013, the Department implemented a monitoring and evaluation process for all curriculum which will be used to identify when curriculum needs to be revised, and the applicable professional development sessions required.

Non-Curriculum Professional Development

The Department had no documented process for identifying professional development that was non-curriculum based. Initiatives were often identified by Government directives or as part of the Department Strategic Plan and in consultation with the District in planning and priorities meetings.

Finding

3. The Department had no documented process in place to identify, prioritize, and select topics for non-curriculum based professional development initiatives other than initiatives identified by Government directive or in its strategic plan.

District Process

The District topics for teacher professional development were primarily selected using the District and the Department strategic plans and/or school development plans, which were closely aligned. Each school generally held two close-out days per year to review student and other data and develop a plan for their own school. The school development plan included achievement data, goals for the coming year with strategies and indicators of success, professional development required to meet the goals, and a report on the previous year plan. In addition, school administration oversaw personal growth plans for teachers. District staff also monitored school data, met with teachers and provided support where issues were identified to aid in teacher professional development. The District also carried out district-wide professional development based on the strategic plans of the Department and District.

Finding

4. The District had processes in place to identify, prioritize, and select topics for professional development.

1C. Establishment of Overall and Sessional Goals

Introduction

Overall goals for teacher professional development should be established and clearly communicated. It is important that all those involved in the professional development of teachers have a common understanding of the overall objectives of professional development. Effective professional learning requires focus on clear, specific targets and outcomes of student learning, and that these be aligned with school, District, and Department goals. We would expect that each professional development session have predetermined goals for what is expected to be learned and outcomes established for each session.

Predetermined Professional Development Sessional Goals

For the sample of 52 professional development sessions examined, predetermined goals were established for each session, however, there were differences in how specific these goals were. For example, some goals were to provide teachers with the new curriculum or prepare teachers to deliver the new curriculum. However, one region communicated specific goals, objectives and overviews for individual professional development topics through an online program schedule for 2013-14 that was shared with school administration and teachers.

Although each session in our sample could relate to the Department or District strategic plan or school development plans, we noted that the goals contained in these plans were not always specific. For example, the 2014-17 Strategic Plan of the Department had goals for enhanced opportunities for student success and improved access to appropriate learning environments. The 2014-17 Strategic Plan of the District had goals for enhanced student success in literacy and numeracy and enhanced schools environments to ensure students learn in safe, caring and healthy settings. School development plans had more detailed goals but again usually referred to improved student achievement or increased opportunities for collaboration rather than setting specific targets to increase student grades or other student outcomes.

Predetermined Overall Goals

Funding was provided for teacher professional development in order to maintain a highly qualified workforce to effectively deliver programs in a changing education environment. The Department Professional Learning Model for new curriculum listed the attributes and characteristics of effective learning, however, there were no specific targets or outcomes included.

The overall goals for the District were included in their strategic plan but did not provide goals specifically for teacher professional development or specific targets and outcomes for student learning. In addition, the District Professional Learning Model demonstrated structure and responsibility for sessions but did not include overall goals for professional development.

Findings

5. For the professional development sessions sampled, predetermined goals were established but there were differences among the four regions on how specific the goals were and on how they were communicated to staff.

6. Overall goals for teacher professional development were established by the Department, however, the Department and the District did not have specific targets or outcomes from student learning.

2. Implementation of Teacher Professional Development

Objective

To determine whether professional development for teachers was properly implemented.

Conclusion

The Department of Education and Early Childhood Development had developed a Professional Learning Model which was intended to be used for delivery of professional development related to new curriculum, however, the Newfoundland and Labrador English School District did not always implement professional development sessions in accordance with the Department Model or on a consistent basis across the District. While the District indicated it required flexibility in the delivery of professional development in order to respond to specific circumstances, there is a risk that the outcomes of the professional development sessions intended by the Department when the Learning Model was developed may not be achieved if the Model is not followed. The Model was not followed in a number of instances as a result of insufficient or inappropriate resources.

Schools did not always complete the required training or had the necessary resources to ensure the curriculum was properly delivered to students.

Our review considered whether professional development was accessible and provided across regions and schools in accordance with professional development models.

Introduction

The responsibility for teacher professional development is shared between the Department, the District, and the schools. The Department implemented a Professional Learning Model in 2009 and the District implemented a Professional Learning Close-out Model in 2014-15. We would expect the Department and the District to provide teacher professional development in accordance with the models.

Department Sessions

Our review of a sample of 19 Department professional development sessions related to two non-curriculum and three curriculum topics identified the following:

- All sessions for each of the five topics had similar agendas and presentations for all regions and, therefore, the content of the sessions was consistent across each region.

- Our sample of professional development sessions for the three curriculum topics included English Language Arts (ELA) Grade 1, Visual Arts Grade 9 and Math 3200, which were implemented during the period from September 1, 2013 to October 31, 2014. We reviewed the sessions held in each of the four regions of the District to determine if the sessions were delivered through the three components as recommended by the Department's Professional Learning Model. Our review identified that the sessions were not always implemented in accordance with the Department's Professional Learning Model. Table 2 provides an overview of the sample results.

Table 2

Teacher Professional Development
Implementation of Curriculum Professional Development Sessions
Sample Results

Curriculum Training	Department Model Requirements					
	Component 1		Component 2		Component 3	
	Size	Timing	Size	Timing	Size	Timing
	Individual or small groups	May or June prior to school year	Groups of 2 to 10	May or June after reflection on Component 1	Large groups	Fall of school year
ELA - Grade 1						
Region #1	Yes	No	No	No	Yes	Yes
Region #2	Yes	No	No	No	Yes	Yes
Region #3	Yes	No	No	No	Yes	Yes
Region #4	Yes	No	No	No	Yes	Yes
Math 3200						
Region #1	Yes	Yes	Yes	No	Yes	Yes
Region #2	Yes	Yes	No	No	Yes	Yes
Region #3	Yes	Yes	Yes	No	Yes	Yes
Region #4	Yes	Yes	Yes	No	Yes	Yes
Visual Arts - Grade 9						
Region #1	Yes	No	No	No	Yes	Yes
Region #2	Yes	No	Yes	No	Yes	Yes
Region #3	Yes	No	Yes	No	Yes	Yes
Region #4	Yes	No	Yes	No	Yes	Yes

The District indicated that it was not required to follow the established Department Model for delivery of curriculum professional development and that flexibility was required in order to respond to specific circumstances arising related to individual sessions.

The Department and the District indicated that the Department Model was not being followed due to various resource and scheduling issues and with certain implications. For example:

- Materials were not ready, facilitators were not available until the Fall, training for program specialists and lead teachers was provided in May thereby not allowing enough time for Spring sessions, and three regions indicated that the Fall was more effective as teacher assignments were not completed until then and costs would be reduced.

- Even though students had been taught the revised curriculum starting in September 2014, Component 2 for Visual Arts for one region was not held until January 2015 after component 3, which was held in October 2014. The Department model recommended that component 2 be held in the previous Spring, prior to the completion of component 3.

- Even though students had been taught the revised curriculum starting in September 2014, components 1 and 2 for Visual Arts for one region were not held until February and March 2015 after component 3, which was held in September 2014. The Department model recommended that components 1 and 2 be held in the previous Spring, prior to the completion of component 3.

Our review also identified instances where schools did not always complete the required training or had the necessary resources to ensure the curriculum was properly delivered to students. For example:

- The three curriculum topics had been offered to all schools throughout the District, however, one region reported that two schools did not complete any of the three components and another school in the region did not complete components 1 and 2 of the Visual Arts training session. District staff noted that the training was necessary as the new curriculum required technological competence in many areas which was not included in the former curriculum. It was not clear whether the Department was aware that the required training was not received, as the Department indicated that the specific administration of the session was a District responsibility and attendance was kept at the District.

- District program staff identified technical issues in the implementation of Visual Arts at many schools across the Province. An integral part of the new Visual Arts program, which was being taught since September 2014, was a software program for animation activities. Program staff identified the following:

    - 27 schools in three regions reported the software was not installed, not functioning properly or more computers were needed; and

    - one region indicated that some schools did not have computers compatible with the software chosen by the Department and had to use a different software to meet the course outcomes.

Findings

7. None of the three professional development sessions directed at new curriculum that we sampled were implemented in accordance with the Department Professional Learning Model. The District indicated that it was not required to follow the established Department Model and that it required flexibility in the delivery of professional development in order to respond to specific circumstances.

8. The Department Professional Learning Model for new curriculum was not followed due to various resource and scheduling issues. For example, materials were not ready, facilitators were not available until the Fall, training for program specialists and lead teachers was provided in May thereby not allowing enough time for Spring sessions, and three regions indicated that the Fall was more effective as teacher assignments were not completed until then and costs would be reduced.

9. Three schools did not receive the required professional development training for one new curriculum professional development topic included in our sample. One region reported that two schools did not complete any of the three components and another school in the region did not complete components 1 and 2 of the Visual Arts training session.

10. Schools did not always have the proper resources for one new curriculum included in our sample, before the curriculum was taught to students. For example, 27 schools in three regions reported software was not installed, not functioning properly or more computers were needed.

District Sessions

The Collective Agreements for teachers requires three professional development/in-service days to be scheduled by the District each year. The District scheduled five close-out days for each school as part of its learning model, and, therefore, complied with the Agreements.

Our review included a sample of 33 professional development sessions for eleven District topics carried out in regions across the Province. Our review indicated the content of the session presentations for each of the topics was consistent, and where applicable, all schools in each region had or were scheduled to be provided the opportunity to receive professional development for all topics in our sample.

Our review of the District Professional Learning Close-out Model identified the following:

- Although five close-out days were scheduled for the 2013-14 school year, there were schools where only three close-out days were used for professional development because of sessions being cancelled due to weather, however, the missed days were not rescheduled.

- The District Professional Learning Close-out Model scheduled one of the five close-out days to be used for curriculum training, however, one of the four regions' professional development sessions for curriculum were not incorporated into its close-out days due to the high number of teachers in the region and the inability of the one Program Specialist to deliver the session to all teachers in the region. The region provided curriculum training through the use of substitute teacher time rather than through the use of a close-out day. As a result, the District Model was not consistently applied to all regions.

Findings

11. The District had scheduled three professional development days each year as required by the teacher collective agreements.

12. Some schools did not provide five close-out school days as provided by the District Professional Learning Close-out Model as a result of weather cancellations and additional close out days were not scheduled.

13. The District Professional Learning Close-out Model scheduled one of the five close-out days to be used for curriculum training, however, one of the four regions professional development sessions for curriculum were not incorporated into its close-out days. As a result, the District Model was not consistently applied to all regions.

3. Monitoring of Teacher Professional Development

Objective

To determine whether professional development for teachers was properly monitored.

Conclusion

The Department of Education and Early Childhood Development and the Newfoundland and Labrador English School District did not always:

- complete evaluations of professional development sessions;
- monitor teacher professional development to determine whether overall program and sessional objectives were met;
- record and monitor teacher attendance; and
- record and monitor teacher professional development expenditures.

Our review considered whether:

- Teacher professional development sessions were evaluated through the use of various outcome measures;

- The Department and District periodically monitored overall teacher professional development activities in the K-12 education system;

- Teacher attendance was recorded and followed up to ensure that professional development was provided to teachers as required; and

- Teacher professional development budgets were prepared and approved, expenditures were properly supported, recorded, and approved, and actual costs were compared to budget amounts, variances explained and action taken where required.

3A. Evaluation of Teacher Professional Development Sessions

Introduction

Evaluation is important if professional development is to be effective and efficient. Teacher professional development should be evaluated through the use of various outcome measures such as teacher satisfaction, quality of the experience, professional learning, teaching practices and student outcomes. Effective evaluation is an ongoing process, not an event that occurs at the end of a session.

Department Evaluations

The roles of the Department and the District in the evaluation process lacked clarity. For the three new curriculum programs sampled, Department staff indicated that the District was responsible for the evaluation of professional development sessions. However, for four of the twelve new curriculum sessions sampled, District staff indicated that the analysis and results of the evaluations were being carried out by the Department.

For the two Department non-curriculum sessions we reviewed, evaluations were completed by teachers and analyzed by the Department. The Department indicated that it planned to evaluate the two programs, once fully implemented, using data analysis and summary reports that included student outcomes.

Findings

14. The roles of the Department and the District in the evaluation process lacked clarity as District staff indicated that the analysis and results of the evaluations for four of the 12 curriculum sessions that we sampled were being carried out by the Department, even though the Department indicated that the evaluation for curriculum sessions was a District responsibility.

15. For the two Department non-curriculum sessions we reviewed, the Department analyzed teacher evaluations and planned to evaluate the two programs once the programs were fully implemented.

District Evaluations

The District did not have documented policies and procedures for the evaluation of the effectiveness of professional development sessions. As a result, there were inconsistencies as to whether evaluation forms were completed, what was included in the evaluation, or how the results were summarized and reported. Our review of a sample of 33 sessions that required evaluations by the District identified the following:

- 18 sessions had no evaluation forms completed.

- 15 sessions had evaluation forms completed and District staff indicated that:

    - the results for six sessions were analyzed and reported and documentation was provided;

    - the results for three sessions were not analyzed or reported; and

    - the results for six sessions were analyzed and reported but documentation was not provided of this analysis and reporting.

- There was no standard evaluation forms used between the District regions or within the regions. The extent of the evaluation process was determined mainly by the Program Specialist facilitating the session.

In addition to evaluation forms, District staff indicated there was ongoing evaluation and feedback on the use of concepts learned at each session through school visits, phone calls, teacher conferences, observations, walkthroughs and staff meetings. However, documentation could not be provided due to the nature of the evaluations and it was not clear whether the informal evaluations related to specific topics or general discussions.

Findings

16. The District did not have documented policies and procedures for the evaluation of the effectiveness of professional development sessions to ensure sufficient information was gathered during the evaluation process to determine whether the professional development was effective, that evaluations were always completed, and the results were analyzed and reported.

17. For our sample, the District did not always complete evaluations or analyze and report the evaluation results for professional development sessions.

18. The District indicated that it carried out informal evaluation and feedback throughout the year but due to the nature of the activities, there was no supporting documentation.

3B. Monitoring of Overall Teacher Professional Development Activities

Introduction

Professional development should focus on teachers' acquisition of knowledge and skill, and connect assessments to student learning. It is important to track overall progress against an effective teacher professional development objective.

Teacher Professional Development Tracking

There was no database to track professional development training. A database would assist the District and the Department in tracking and monitoring teacher professional development that was planned and whether teachers received the necessary training. To provide documentation for our review, the Department and the District had to compile listings for each region resulting in significant time delays, different types of listings, and concerns regarding whether the listings were accurate and complete.

Finding

19. There was no system in place to track the professional development training that each teacher received.

Department Overall Monitoring of Activities

The Department did not monitor and report on the effectiveness of overall professional development and whether its objective to maintain a highly qualified workforce to effectively deliver programs had been met. While the Department did have a policy for monitoring curriculum programs and a five year curriculum plan, the focus was more on the content of programs rather than the professional development of teachers. However, given that curriculum is the responsibility of the Department, a more active role would be expected in this area. For example, the Department was not monitoring whether all schools and all teachers received all their recommended training for the implementation of new curriculum. In addition, the Department was responsible for student achievement and various student assessment reports were available on the Department's website but it was not clear how the Department used this data to identify trends, needs, and issues related to professional development.

Finding

20. The Department did not monitor and report on the effectiveness of overall teacher professional development to maintain a highly qualified workforce. The Department did not monitor whether all teachers received the required training or the impact of professional development on student achievement.

District Overall Monitoring of Activities

The District had developed processes to connect professional development to student achievement at the school level. Specifically:

- All schools held at least two school development days per year where internal and external achievement data was reviewed to develop action plans which included professional development for areas with an assessed need. The action plans were included in each School Development Report and submitted annually to the District. At the school development days, staff also discussed the impact of last year's action plans on student achievement and a report on last year activities was included in the School Development Report.

- In addition to this analysis by schools, District staff analyzed internal and external achievement data and discussed the results with principals and the Department. Based on the achievement results, staff completed school intervention plans and provided in class training where necessary.

Although the District had processes in place to connect professional development to student achievement at the school level, the District did not assess the effectiveness of overall teacher professional development. Professional development activities were discussed at regular team meetings and various program specialists prepared year end reports, but an overall assessment was not conducted on whether the professional development needs of teachers were met or student achievement was effected.

Finding

21. While the District had processes in place to monitor teacher professional development at the school level, there was no assessment on the effectiveness of overall professional development.

3C. Monitoring and Follow-up of Attendance

The Department indicated that attendance was the responsibility of the District and, therefore, they did not monitor or follow-up teacher attendance at professional development sessions. The District did not have a policy for monitoring attendance or any requirements for training for those absent from a professional development session. Program specialists were responsible for determining the level of training to be provided to absent teachers, which was dependent on the type of session.

Our review of teacher attendance at professional development sessions identified the following:

- Each of the four regions reported different procedures for recording attendance. For example:
    - Two regions indicated attendance was recorded by District staff for new curriculum sessions and attendance at non-curriculum sessions were the responsibility of the schools.
    - One region indicated attendance was the responsibility of the school, however, District staff monitored teacher attendance and provided follow-up training when needed.
    - One region indicated that District staff were required to track attendance at sessions facilitated at the District level, however, school-based sessions were the responsibility of the schools.
- Our review of attendance at a sample of 52 sessions identified the following:
    - Three sessions did not require attendance to be taken due to the nature of the sessions (i.e. one-on-one classroom sessions).

- For 16 sessions, attendance information was not provided. District staff often indicated it was the responsibility of the schools to take attendance, however, six sessions were held outside of the school and therefore, school administration would not have been able to verify whether teachers had attended or not.

- For 33 sessions, attendance information was provided which indicated that 56 teachers were absent from fifteen sessions.

    - As of January 2015, 39 of the 56 teachers had not yet had follow-up training provided. For the 17 teachers that had follow-up training, staff indicated that the presentations, materials and sessions were provided but often for a shorter time period than the original session.

    - 35 of the 56 teachers absent were to have attended the revised Visual Arts session. The District provided various reasons for the absenteeism, such as illness, lack of substitute teachers, availability of software, or conflicts with another professional development session, however, in some instances, no reason was provided to them.

- The Department indicated the target group for all new curriculum components should include all teachers of the respective course being implemented and one Instructional Resource Teacher (IRT) from each school. Our review identified that for one region, the IRTs only attended two of the three components provided.

Findings

22. The Department and the District did not have a policy to monitor attendance and provide follow-up training.

23. The District did not have consistent practices across each of its four regions for recording attendance at professional development sessions.

24. For our sample, the Department and the District did not always record and monitor attendance for professional development sessions.

25. For our sample, teachers did not always attend sessions and follow-up training was not always provided.

3D. Monitoring of Teacher Professional Development Expenditures

Introduction

Monitoring of expenditures should compare actual expenditures to budgeted amounts, explain variances and initiate action where necessary. The amount of funding should be aligned with needs, include a plan for all teacher professional development activities and consider spending at all levels in the education system (i.e. Department, District and school).

Department Monitoring of Expenditures

Teacher professional development expenditures included such costs as venue rentals, course registration fees, materials, travel expenses, substitute teacher costs and grants to the Districts and other educational agencies. For the year ended March 31, 2014, the Department reported spending $7.9 million (2013 - $8.7 million) on teacher professional development expenditures. Our examination of Department expenditures identified the following:

- There were significant expenditures included in the Department expenditure activity that were not related to teacher professional development. Table 3 provides a summary of our analysis.

Table 3

Department of Education and Early Childhood Development
Teacher Professional Development
Department Expenditure Analysis
For the Years Ended March 31

Department Expenditures	Actual 2013	Actual 2014
Allowances and assistance	$5,045,842	$4,791,916
Grants and subsidies	3,613,144	3,113,469
Total reported expenditures	**$8,658,986**	**$7,905,385**
Less: substitute teacher costs not related to professional development	1,172,552	1,215,853
Less: Student textbooks	793,005	845,403
Less: Other expenses not related to professional development	1,362,257	952,922
Adjusted total expenditures	**$5,331,172**	**$4,891,207**

Source: Province of Newfoundland and Labrador Public Accounts and 2015 Estimates and Department staff

As Table 3 indicates, only $4.9 million of the $7.9 million (or 62%) reported by the Department as professional development was actually spent on teacher professional development for the year ended March 31, 2014. Substitute teacher costs for family leave and other leave not used for teacher professional development were recorded as professional development activity. In addition, textbooks for students and other expenses that were not for teacher professional development were also recorded as professional development. As a result, variances and funding gaps for teacher professional development may not be readily apparent and the ability to monitor other types of expenses is impaired.

- For the fiscal year ended March 31, 2014, the Department recorded $2,725,669 for substitute costs, or 56% of the total expenditures related to teacher professional development. As part of our review, we planned to examine 30 individual transactions from these expenditures to determine that the cost was incurred for a teacher to attend a professional development session and that the substitute request form was appropriately approved in advance by District staff.

  We requested the substitute leave forms for these 30 teachers from the District, however, the District could not provide all the leave forms as requested in a timely manner because the forms were not on file at the District or regional offices. As a result, we could not confirm that the expenditures charged to the professional development activity were for a teacher to attend a professional development session or whether the request was properly approved in advance.

Findings

26. Expenditures of approximately $3.3 million for the year ended March 31, 2013 and $3.0 million for the year ended March 31, 2014 were reported by the Department as teacher professional development even though the expenditures were not for teacher professional development. As a result, variances and funding gaps for teacher professional development and other expenditures may not be readily apparent.

27. The District could not provide leave forms for a sample of 30 teachers as requested. As a result, we could not confirm that the substitute costs recorded by the Department were for a teacher to attend a professional development session or whether the request was properly approved in advance.

District Monitoring of Expenditures

For the fiscal year ended June 30, 2014, the District spent $907,725 for teacher professional development. The District budget, which included expenditures for professional development, was approved annually and submitted to the Department. For the fiscal year ended June 30, 2014, quarterly budget status reports were presented to the Board in accordance with the District Budget Policy.

In addition to the teacher professional development expenditures reported by the District, the Department allocated approximately 2.5 days annually per teacher to the District for discretionary leave days. Discretionary leave was not only being used for professional development, it was also used by teachers for family leave, Board approved days, and other curricular activity. Our review identified that the District was not adequately monitoring discretionary leave days. The District did not allocate the 2.5 discretionary leave days by type of leave and the District could not provide the actual days taken by teachers during the school year ended June 30, 2014. Given that these discretionary days are used for various purposes, it is important that the District monitor discretionary leave requirements for teacher professional development to ensure they are sufficient to meet the training needs of teachers.

Finding

28. The District did not determine whether there were sufficient discretionary leave days available to meet the needs of teacher professional development.

Recommendations

1. The Department and District should consider reviewing and revising their professional learning models to include the characteristics of effective professional development and agree on the best models to consistently implement professional development across the District.

2. Overall professional development and individual session goals should be specific and communicated consistently across all regions of the District, with established targets linked back to student outcomes, where possible.

3. The District should provide professional development to teachers in accordance with established learning models.

4. The District, in consultation with the Department, should establish a professional development policy on the recording and monitoring of attendance, and the training of absent teachers.

5. The District, in consultation with the Department, should establish a policy on evaluation processes to be used to evaluate the quality and effectiveness of professional development sessions.

6. The District, in consultation with the Department, should maintain an information system to record professional development sessions and teacher training.

7. The Department and District should monitor and report on the overall effectiveness of teacher professional development towards maintaining a highly qualified workforce and achieving desired student outcomes.

8. The Department should ensure expenditures recorded to the teacher professional development activity code are legitimate professional development expenses.

Department Response

Recommendation 1

The Department and District should consider reviewing and revising their professional learning models to include the characteristics of effective professional development and agree on the best models to consistently implement professional development across the District.

The professional learning model supported by the Department is guided by principles that describe essential elements of effective professional learning. These principles state that professional learning:

- *occurs in collaborative, reflective communities*
- *is guided by student and teacher learning needs*
- *is designed to foster change in practice*

The model supports a focused, yet self-directed route towards professional learning that is ongoing and collaborative, embedded in daily practice, and tailored to meet specific student and teacher learning needs.

The Department has been refining the model, and in consultation with the school districts, will continue to do so to ensure it reflects the characteristics of effective professional learning and is founded on the latest research and best practices.

Recommendation 2

Overall professional development and individual session goals should be specific and communicated consistently across all regions of the District, with established targets linked back to student outcomes, where possible.

In fulfilling its obligation to provide professional learning opportunities, the Department has developed standards for professional learning planning and content, as articulated in Program Development's Policies and Procedures handbook (Policy 6.1). Professional learning components should focus on teaching and learning, assessment and evaluation, and reflection. The goals for each module of the supported professional learning model are stated in Appendix 6-1. The appendix also contains required, as well as suggested, content for the Orientation module.

The Department would have shared these goals of the recommended model with the districts. However, for future professional learning activities we will work to formalize this process.

Recommendation 4

The District, in consultation with the Department, should establish a professional development policy on the recording and monitoring of attendance, and the training of absent teachers.

Recommendation 5

The District, in consultation with the Department, should establish a policy on evaluation processes to be used to evaluate the quality and effectiveness of professional development sessions.

Recommendation 6

The District, in consultation with the Department, should maintain an information system to record professional development sessions and teacher training.

The Department recognizes its leadership role within the Newfoundland and Labrador education system and so commits to working with districts as it establishes policies and procedures related to professional learning; monitoring, evaluation and tracking.

Recommendation 7

The Department and District should monitor and report on the overall effectiveness of teacher professional development towards maintaining a highly qualified workforce and achieving desired student outcomes.

The Department will; through provincial, national and international testing as well as other quantitative methods, continue to monitor student achievement and ultimately the efficacy of the public K-12 education system. We are committed to working with the school districts to establish clear policy as it pertains to the evaluation of teacher professional learning.

Recommendation 8

The Department should ensure expenditures recorded to the teacher professional development activity code are legitimate professional development expenses.

It should be noted that expenses charged to the teacher professional development activity were for items that were budgeted within the teacher professional development activity code. The Department acknowledges that some expenditures historically budgeted and expensed to the professional activity code would be more accurately budgeted and expensed to other accounts. The Department is reviewing the professional development activity to correct this going forward.

District Response

Introduction

The Newfoundland and Labrador English School District (NLESD) was formed on September 1st, 2013 from the merger of four former English school districts (the Labrador School District; the Western School District; the Nova Central School District; and, the Eastern School District). The provincial office for the NLESD is located in St. John's and it has four regional offices (Goose Bay, Corner Brook, Gander and St. John's). Each region is managed by an Assistant Director of Education (Programs). The new district's vision, as articulated in its 2014-2017 strategic plan, is that of an educational leader preparing all students to achieve to their fullest potential in a safe and caring environment. Achieving this vision requires ongoing high quality teacher Professional Learning (PL) that adheres to research supported principles of effective PL. The principles inherent in the PL philosophy and theoretical framework are that effective PL focuses on sharing best practices through job-embedded, and continuous learning opportunities throughout a teacher's career. Professional Learning is also most effective when it involves collaborative sharing through peer interactions/coaching and when there is a firm focus on, and connection to, student learning priorities.

It is important to note that the PL program of the NLESD is planned and implemented in a manner that enhances teacher learning and student achievement, and is monitored to help ensure overall ongoing success. There are three main types of PL which occur in the District:

1) *PL opportunities that are specific to various curricula and the teachers with responsibilities for these (e.g., Grade 3 Math, or Grade 10 English);*
2) *School wide topics that are applicable to all staff (e.g., differentiated instruction, assessment and evaluation practices); and/or,*
3) *Individual teacher learning priorities related to curricular or generic programming needs, or aligned with the District's strategic priorities (e.g., K-6 Literacy, numeracy or Safe and Caring Schools).*

PL occurs during school close-outs (as articulated in our PL Close-out Model), or at other times throughout the year when teachers are released from their regular duties through the use of substitute teacher time or through program specialists or itinerants working in real time with teachers in their classrooms. For PL priorities focused on initiatives that have broad-based implications for an entire school or District staff, full school or system closeouts are the only sustainable and feasible method of delivery. In addition to PL supported by the NLESD, many teachers also avail of PL opportunities on their own time during evenings, weekends and over the summer months, as part of their own professional growth plans.

The 2013-2014 school year was the first year of operation for the NLESD and the process of merging the four former school boards was undertaken during that year. Until policies, systems and processes are fully merged, each region of the new district operates according to past practice (including for the delivery of PL) where necessary. During this time, the NLESD has provided general direction for topics and priorities for PL, and has begun working toward a consistent framework for its delivery. While significant progress has been made, we recognize there is much to be done as we continue with the merger process and the many strategic consolidation efforts necessary to build an effective learning culture that supports achievement of the District's vision.

The provision of high quality PL opportunities to better position teachers to more effectively facilitate the teaching-learning process represents an essential aspect of our work, and we continually seek to improve the quality of these opportunities for our staff. In that light, the District certainly values and welcomes the input received from the Office of the Auditor General and will use the recommendations provided as it continues to merge the four previous English school districts into a new learning organization, particularly as it works to consolidate and enhance its PL delivery for teaching staff across the four regions.

Recommendation 1

The Department and District should consider reviewing and revising their professional learning models to include the characteristics of effective professional development and agree on the best models to consistently implement professional development across the District.

The NLESD continues to review and enhance its PL model to reflect the characteristics of effective professional development. Furthermore, the NLESD will continue its efforts to work with the Department of Education and Early Childhood Development (DEECD) to ensure that the best models are consistently implemented for PL delivery.

The DEECD and NLESD approaches to PL for new curricula have a common theoretical framework, are generally well aligned, and are built on common understandings of the characteristics of effective professional learning. As noted above, both the District and Department implement the Professional Learning Communities (PLC) philosophy and theoretical framework. The DEECD's PL Model for new curricula is built on this framework, and this model is utilized by the NLESD where deemed practical, cost-effective and appropriate. The DEECD PL Model has been developed as a recommended approach to organize and deliver PL for new curricula, but it is not a compulsory model for school districts to follow.

Professional Learning for new curricula represents only a portion of the total PL events delivered by the NLESD in any given year. A variety of other teacher PL is offered by the NLESD including topics addressing legislative requirements such as Occupational Health and Safety and First Aid, as well as school-wide topics such as anti-bullying initiatives or strategic planning priorities relating to literacy and numeracy. The NLESD applies all aspects of the DEECD PL model in situations where it is deemed more effective than other approaches, typically when schools are located in more urban and easily accessible locations. However, for schools in more rural and remote locations, it is difficult to use all aspects of this model. In these circumstances, other models/approaches to delivery of PL are often more appropriate.

The District acknowledges the Auditor General's recommendation and will continue its longstanding practice of working collaboratively with the DEECD regarding continued possible alignment of principled PL models to support implementation of new curricula and to clearly articulate the variety of PL opportunities available to teachers.

Recommendation 2

Overall professional development and individual session goals should be specific and communicated consistently across all regions of the District, with established targets linked back to student outcomes, where possible.

The Newfoundland and Labrador English School District agrees that overall professional development and individual session goals should be specific and communicated across the District, and linked to student outcomes where applicable and possible.

The NLESD agrees that in situations where it can be achieved (e.g., new curricula or strategic priorities), it is important to identify common goals across all regions of the District. As indicated above, PL falls into a number of categories ranging from a focus on new curricula to a focus on priorities emanating from the NLESD's strategic plan. All PL sessions have broad goals and specific objectives that help to guide the nature and content of the sessions and how they are delivered. District personnel are working to establish a common framework for the delivery of PL for teaching staff throughout the province, while allowing for appropriate flexibility in each of the regions with respect to the specific focus and method of delivery. For instance, the NLESD has a common goal regarding literacy, but because there are variations in the extent of regional implementation based on prior district progress, and given the variation in the number and location of teaching staff who participate in PL sessions, there may be variations in the specific objectives across regions. While the variations in implementation will diminish over time as the new district streamlines its PL work in particular priority areas, demographic and geographic variations will remain, and these dynamics must be continually considered when planning to deliver PL to schools that will ultimately benefit the students we serve.

To assist with realignment of PL processes and practices, the District has begun developing an on-line system that records information on professional development sessions, including the session agendas and goals. Once fully functional, this system will address the specific issues identified in the Auditor General's review, and will also track relevant information regarding the types of PL a teacher has participated in.

In support of the Auditor General's recommendations, PL linked to the student learning goals in the strategic plan will be specific and communicated across all regions, with necessary adjustments being made to more specifically address regional PL differences.

Recommendation 3

The District should provide professional development to teachers in accordance with established learning models.

Ensuring PL for teachers through effectively established learning models is an important consideration for any learning organization. The NLESD has given serious consideration to this matter and believes it is providing PL in accordance with evidence-based learning models.

The NLESD has an established PL program that facilitates teacher PL for new curricula, for generic programs-focused priority topics and for priorities relating to the goals in school or NLESD strategic plans. As previously stated, the NLESD PL program operates within the PLC philosophy and theoretical framework which has widespread empirical support as an effective way to organize and deliver staff PL. This approach to PL is guided by four critical questions popularized by well-known researcher and practitioner, Richard DuFour. These four questions, which have penetrated and shaped the culture and climate across the NLESD's regions and helped to clarify the District's focus on teaching and learning, include the following:

1) *What do we want students to learn?;*
2) *How do we know if and when they have learned it?;*
3) *What do we do if we discover they have not learned it?; and,*
4) *What do we do if we discover they have learned it?*

Organizing the District's PL work around these four student-centered questions helps to ensure alignment of PL sessions with priorities emanating from new curricula, and the priorities relating to each school's and the District's strategic plans. Essentially, the PL program in any given year helps to ensure teachers receive PL related to the needs arising from the introduction of new curricula, as well as individual teacher, school and district priorities relating to student performance on curricular outcomes.

The NLESD PL program follows the general approach developed many years ago by the former school districts that are now subsumed under the new district. This approach is well grounded in research-supported principles of effective PL and has the inherent flexibility necessary to ensure teacher PL needs can be met in a broad range of circumstances. One significant component of the NLESD's PL program is the School Close-out Model that affords schools up to five days for PL related to a range of topics, including new curricula and strategic priorities. PL for teaching staff is delivered through a variety of methods including face-to-face sessions, on-line learning venues and PL embedded in the classroom or school and facilitated by program specialists and itinerant teachers. The model used is determined by a number of factors such as, the number of teachers, geography and materials/content to be covered. Another avenue to deliver PL includes the use of substitute teacher time to release teachers from their regular duties for a day or two to allow them to focus on the PL needs in particular areas.

As the NLESD matures into a new learning organization, it will continue its efforts to monitor and evaluate its PL program and overall approaches to PL delivery with a view to ensuring this aspect of its operation continues to function at an optimal level in alignment with research-supported principles and practices of highly effective PL for staff.

Recommendation 4

The District, in consultation with the Department, should establish a professional development policy on the recording and monitoring of attendance, and the training of absent teachers.

The NLESD agrees with this recommendation of the Auditor General and is currently working to improve the recording and monitoring of attendance at teacher PL sessions as the District recognizes that this is an area where improvements can and will be made.

In any given school year, there is a need to deliver repeat PL sessions for teachers who missed the original session(s) for a number of possible reasons, including absenteeism because of illness or other approved leave, or because they were not hired at the time the session was delivered. Similar to the four former school districts, the NLESD has adopted practices to monitor attendance and to address PL needs for those who did not avail of the first opportunity.

As previously noted, the District has begun developing an on-line system that records information on professional development sessions, including the tracking of registration and attendance. Once fully functional, this system will address the specific issues identified in the Auditor General's review, and will also track relevant information regarding the types of PL a teacher has participated in over time.

While it will be a significant and expensive undertaking, we anticipate an online tracking system will have a dual benefit because of its ability to effectively identify individuals for whom the organization must arrange repeat PL sessions, and its ability to efficiently document each teacher's annual PL experiences with the NLESD. These two features will prove useful for both the organization and individual teachers who want to generate an accurate summary of their PL experiences over time.

Recommendation 5

The District, in consultation with the Department, should establish a policy on evaluation processes to be used to evaluate the quality and effectiveness of professional development sessions.

The District agrees with the Auditor General that clear and consistent evaluation processes of professional learning sessions are necessary.

The evaluation of PL sessions for staff is a practice established by predecessor districts and has been continued by the NLESD. Evaluation processes include asking participants to complete an evaluation form at the end of sessions or to complete online versions of the forms. As well, District staff have a longstanding practice of conducting detailed examinations of annual and trend student achievement data with a view to inferring the overall effectiveness of PL programs over time, and to identify areas for continued priority PL work. For example, the former districts had practices in place that helped to ensure PL events extended beyond the "one-day inoculation" which included promoting and supporting follow-up sessions among small groups of teachers or job-embedded peer collaboration sessions to help solidify what was learned during the one-day event. These practices have continued with the newly formed NLESD.

The NLESD acknowledges that establishing a more formalized evaluation system that can be effectively and efficiently deployed across regions is an important area for improvement. District staff will work in consultation with the DEECD, where applicable, to develop policy and procedures so both entities are better positioned to make important decisions about the value and effectiveness of various PL events over time. Furthermore, as resources become available, the District is planning to develop an online tool to assist with PL evaluation.

Recommendation 6

The District, in consultation with the Department, should maintain an information system to record professional development sessions and teacher training.

District-level staff in each region of the NLESD currently record relevant information relating to PL sessions by utilizing processes and procedures from the predecessor school districts that formerly operated within these regions. These systems include using electronic data bases for all PL sessions within a region, or more simplistic processes that record individual sessions by discipline or individual staff member. That said, the NLESD acknowledges the relevance and importance of the Auditor General's recommendation and the value that an electronic information system would bring to the organization. The District also recognizes that this will be a significant undertaking with substantial anticipated costs requiring dedicated human resources to develop and to manage thereafter. Nevertheless, the NLESD will continue its efforts to develop and implement a district-wide system that will have broad-based application and benefit for both the NLESD and the DEECD.

Recommendation 7

The Department and District should monitor and report on the overall effectiveness of teacher professional development towards maintaining a highly qualified workforce and achieving desired student outcomes.

Recognizing that the quality PL has a significant impact on overall levels of student success, the NLESD will continue its efforts to monitor the effectiveness of its PL program with a view to making the necessary ongoing adjustments to help ensure a highly qualified workforce for the benefit of all learners.

The research evidence is very clear that the most effective learning organizations provide ongoing quality PL to ensure the quality teaching necessary to maintain high levels of student learning. Empirical evidence indicates that the quality of teaching is the single greatest environmental factor impacting student achievement, and that teacher PL is an essential element in maintaining a highly qualified teaching staff. The research evidence further suggests that models of PL need to adhere to important principles regarding effective PL. These principles include ensuring PL that is job-embedded, continuous throughout a teacher's career, connected to the teacher's work with students, and focused on sharing best practices through collaborative, collective peer interactions/coaching sustained over time.

As previously referenced, the four former English School Districts and the newly created NLESD have developed, delivered and monitored/evaluated PL in the context of the above noted research-supported principals of effective PL. Yet, measuring the impact of quality PL on the teaching and learning process is not a simple task, partly because it can often take years before the impact of PL events, positive or negative, can be determined. Nevertheless, given the known impact of the quality of PL on the teaching-learning process, the District will continue its work in building more effective evaluation and monitoring systems that help to strategically position it to make important decisions regarding the overall effectiveness of its PL program in promoting high levels of learning for all students under its care. As a part of this important work, the District will continue its efforts to foster collaborative engagement with the DEECD.

PART 3.4

EXECUTIVE COUNCIL

OFFICE OF THE CHIEF INFORMATION OFFICER

Summary

The Office of the Chief Information Officer (OCIO) was established in April 2005, bringing together the information technology operations of Government into a central organization.

The OCIO operates as an entity within the Executive Council and is governed by the *Executive Council Act*.

The OCIO consists of four branches: Corporate and Information Management Services, Solutions Delivery, Application Services and Operations.

The OCIO's Solutions Delivery Branch is responsible for providing overall vision, strategy, policy, guidance and leadership in relation to the design, development, implementation and deployment of projects for departments. These projects are managed using the System Development Life Cycle (SDLC) methodology.

As at March 31, 2014, the OCIO had approximately 323 employees, with the majority of these employees located in St. John's. There were 15 employees in regional offices in Happy Valley-Goose Bay, Corner Brook, Stephenville, Grand Falls-Windsor, Gander and Clarenville. The OCIO also had 205 external consultants that each worked, on average, six months during the year ended March 31, 2014. The external consultants were working primarily on system development projects within the Solutions Delivery Branch.

Objectives

The objectives of our review were to determine whether:

1. A project management methodology was being effectively utilized in the design, development, implementation and deployment of system development projects (projects) for Government departments and identified publicly funded bodies; and

2. The OCIO was using its resources effectively in meeting its mandate.

Scope

Our review covered the period from April 2010 to September 2014. We reviewed financial information, policies and procedures, files, records, reports and correspondence, and conducted interviews with OCIO officials. We also performed an assessment of a sample of projects overseen by the OCIO and tested a sample of external consulting contracts and other OCIO expenditures. Sample selections were non-statistical and random.

We completed our review in March 2015.

Conclusions

Objective 1
We found that the project management methodology had been effective for managing project deliverables, but was not effective in managing project costs. We also found that project work utilizing external consultants was not always fully defined and approved.

Objective 2
We determined that the OCIO was not always utilizing its resources effectively in meeting its mandate. Though the OCIO had achieved savings through the creation of certain new salaried positions to replace the hiring of external consultants, there were still positions being filled by external consultants for multiple projects over multiple years that were, in effect, full-time roles that could have been filled by internal employees at a lower cost.

Findings

Project Management

Project Budgeting and Monitoring

1. The OCIO was not able to demonstrate that during the scope period of our review project costs and timelines were being monitored over multiple fiscal years against an overall budget. As a result, multi-year projects may accumulate total costs that are significantly beyond what was originally expected, with no analysis and reporting of any variances between the originally approved budget and actual costs and no documented reasons for the overages.

2. During the scope period of our review, the OCIO was using spreadsheets for annual project tracking and monitoring against funds allocated, which were manually updated. This reliance on spreadsheets and manual updating increased the risk of error and issues not being identified in a timely manner.

3. The volume and costs of change requests associated with the Statements of Work we reviewed were significant, with one Statement of Work having change requests of more than 300% of the value of the original Statement of Work.

4. Some of the change requests we reviewed were being used to approve significant additional work, rather than being used to only initiate a change to the original Statement of Work.

5. For the five projects we reviewed, the project steering committee meetings were not all attended by the required personnel.

6. For the five projects we reviewed, steering committee meetings included appropriate discussions of project status and current issues.

System Development Life Cycle Methodology

7. Based on our review of the OCIO Project Management Reference Guide, there was appropriate guidance available for the technical requirements of projects and the guidance was up-to-date.

8. We did not find evidence of proper approval in 11 of 73 deliverables documents we reviewed.

9. For one of the projects we reviewed, the actual costs detailed in the Closure Report were inaccurate.

10. In one of the five projects reviewed, the documents required by SDLC methodology within Phases 1 and 2 of the project had not been completed as required. Our review determined that there would have been value in completing the documents for Phase 1 in that the purpose and relevance of completing the project would have been evident.

11. A project sizing calculator that was available for use during the scope period of our review was not being utilized when determining the size of projects. Therefore, all relevant dimensions of a project may not have been taken into consideration, which would affect the documentation required.

Administration of Projects

12. The OCIO complied with the Government's *Guidelines Covering the Hiring of External Consultants* in the evaluation and awarding of contracts, as required, within the five projects we reviewed for which Requests for Proposal or Project Opportunity documents had been issued.

13. Within the 60 Work Offers we reviewed, there were 37 instances in which work performed by vendors was started and invoiced to the OCIO before the work was offered and/or approved.

14. For the 60 invoices we reviewed, fees for professional services were appropriately approved.

15. Within the 30 invoices we reviewed that included travel costs, the OCIO was not validating travel expenses before the vendor invoices were paid. Often, travel expenses were unsupported and some appeared to be inconsistent with the contract provisions. These unsupported travel expenses are currently being investigated by the OCIO and possible recoveries may be realized.

Use of Resources

16. During the scope period of our review, the OCIO had achieved annual cost savings of $5.6 million through the creation of new salaried positions to replace the hiring of external consultants.

17. During the period of our review, external consultants remained in at least eight positions for which the OCIO had recognized an opportunity for cost savings through new, approved salaried positions. These positions were within a group of 21 approved salaried positions that were eliminated as a result of budgetary restraint measures.

18. There were 106 external consultants that had worked for two or more consecutive years on more than one project during the scope period of our review. Five position types, in particular, were filled throughout the scope period of our review by 57 of the 106 consultants (54%). The roles performed by these external consultants were, in effect, full-time roles for which internal positions would have resulted in a lower cost.

Recommendations

1. The OCIO should ensure that project costs and timelines are being monitored and documented over multiple fiscal years against an overall budget, and that a process is in place to identify projects that are over budget, in either cost or time.

2. The OCIO should ensure that there is an adequate system in place to monitor project costs.

3. The OCIO should ensure that the level of detail within a Statement of Work is appropriately considered to reduce the need for change requests and the OCIO should carefully consider the circumstances surrounding additional work to determine whether it is more appropriate to prepare a new Statement of Work or a change request. The OCIO may also wish to develop a policy to guide the decision whether a new Statement of Work is required.

4. The OCIO should ensure that project steering committee meetings are attended by all required personnel.

5. The OCIO should ensure that the actual costs detailed in the Phase 4 Closure Report of the SDLC methodology are accurate.

6. The OCIO should ensure that all documents required by SDLC methodology are completed and approved as required and should utilize the project sizing calculator when determining the size of projects.

7. The OCIO should ensure that work is not begun by vendors prior to the completion and approval of a Work Offer.

8. The OCIO should ensure that vendor travel costs are validated against supporting details before an invoice is paid.

9. The OCIO should consider the potential for cost savings through the hiring of Government employees in the place of select external consultants.

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

1. A project management methodology was being effectively utilized in the design, development, implementation and deployment of system development projects for Government departments and identified publicly funded bodies; and

2. The Office of the Chief Information Officer (OCIO) was using its resources effectively in meeting its mandate.

Scope

Our review covered the period from April 2010 to September 2014. We reviewed financial information, policies and procedures, files, records, reports and correspondence, and conducted interviews with OCIO officials. We also performed an assessment of a sample of system development projects overseen by the OCIO and tested a sample of external consulting contracts and other OCIO expenditures. Sample selections were non-statistical and random.

We completed our review in March 2015.

Background

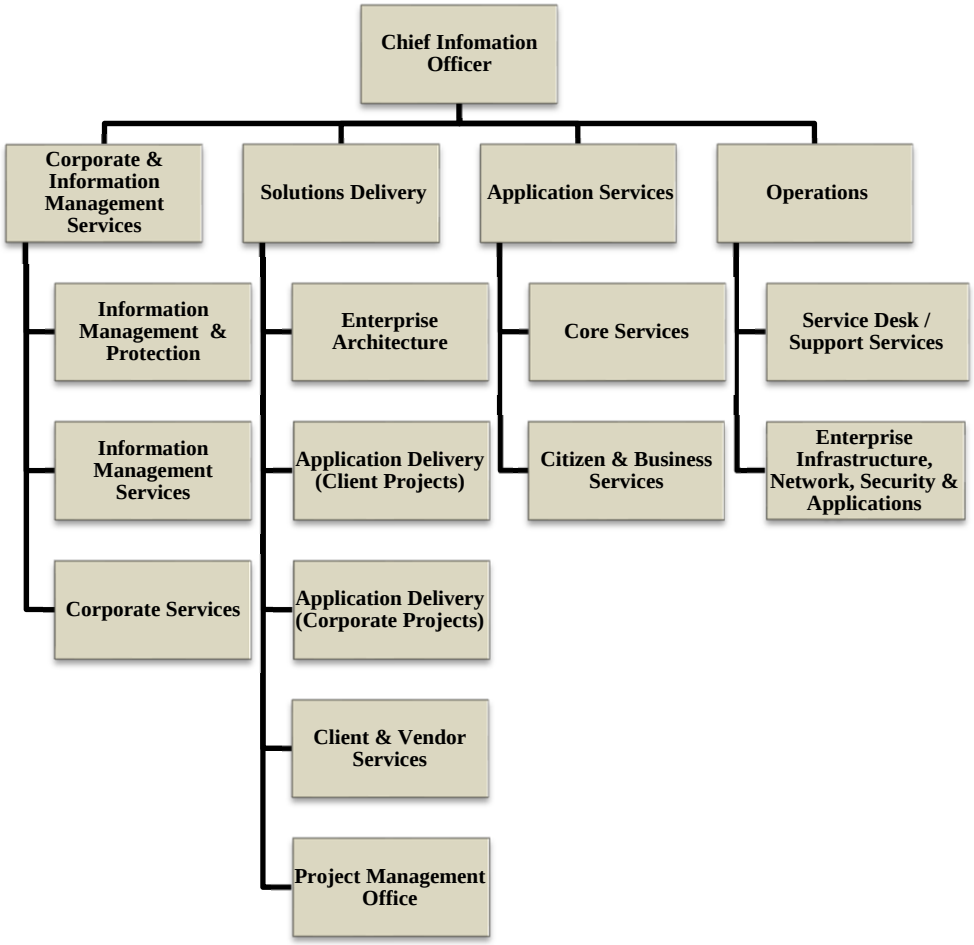
The OCIO was established in April 2005, bringing together the information technology operations of Government into a central organization.

The OCIO operates as an entity within the Executive Council and is governed by the *Executive Council Act*.

The OCIO consists of four branches: Corporate and Information Management Services, Solutions Delivery, Application Services and Operations. Figure 1 shows the organizational structure of the OCIO as at March 31, 2014.

Figure 1

Office of the Chief Information Officer
Organizational Chart
As at March 31, 2014



Source: Office of the Chief Information Officer

As at March 31, 2014, the OCIO had approximately 323 employees, with the majority of these employees located in St. John's. There were 15 employees in regional offices in Happy Valley-Goose Bay, Corner Brook, Stephenville, Grand Falls-Windsor, Gander and Clarenville. The OCIO also had 205 external consultants that each worked, on average, six months during the year ended March 31, 2014. The external consultants were working primarily on system development projects within the Solutions Delivery Branch.

Detailed Observations

1. Project Management

Objective

To determine whether a project management methodology was being effectively utilized in the design, development, implementation and deployment of system development projects (projects) for Government departments and identified publicly funded bodies (departments).

Conclusion

We found that the project management methodology had been effective for managing project deliverables, but was not effective in managing project costs. We also found that project work utilizing external consultants was not always fully defined and approved.

Overview

During the period April 2010 to March 2014, the OCIO spent more than $101 million on 197 projects (Table 1).

Table 1

Office of the Chief Information Officer
Project Expenditures
For the Years Ended March 31

Fiscal Year	Project Expenditures
2011	$27,621,537
2012	28,806,264
2013	27,004,979
2014	17,863,962
Total	**$101,296,742**

Source: Financial Management Information System

The OCIO's Solutions Delivery Branch is responsible for providing overall vision, strategy, policy, guidance and leadership in relation to the design, development, implementation and deployment of projects for departments. These projects are managed using the System Development Life Cycle (SDLC) methodology.

The Solutions Delivery Branch is comprised of four divisions and one supporting office, all of which have responsibilities within the delivery of projects.

The Application Delivery Division has the ultimate responsibility for delivering solutions to the entities supported by the OCIO. There are nine Delivery Managers and two Directors in this Division. Project Managers, who are typically external consultants, are assigned to projects and are responsible for managing the phases of each project. The Project Managers each report to an internal Delivery Manager who has the responsibility of ensuring that the projects within their guidance are being properly managed. Each Delivery Manager reports to one of two Directors.

The Enterprise Architecture Division is responsible to work as part of a project team in the technical design and implementation of a solution and assist the Application Delivery Division in transitioning a solution to production status.

The Client Services Division is responsible to develop relationships with entities supported by the OCIO and to support the Project Manager in client relationship issues during a project. Employees of this Division also meet with departments on a regular basis to provide IT advice and support.

The Project Management Office (PMO) is a supporting arm of the Solutions Delivery Branch. It defines and maintains standards for project delivery and is also a source of documentation, guidance and metrics for project management practices.

We identified findings in the following areas:

A. Project Budgeting and Monitoring
B. System Development Life Cycle Methodology
C. Administration of Projects

1A. Project Budgeting and Monitoring

Introduction

The OCIO is responsible for implementing computer applications and new technologies to support the delivery of programs and services of Government.

Table 2 provides a listing of the 10 projects with the highest overall costs incurred between April 1, 2010 and March 31, 2014, and outlines the total project costs of the 10 projects for each fiscal year.

Table 2

Office of the Chief Information Officer
Project Costs
For the Year Ended March 31
($000's)

Description	2011	2012	2013	2014	Total
Project 1	$2,749	$8,502	$10,000	$4,079	$25,330
Project 2	2,630	1,997	182	-	4,809
Project 3	3,020	924	595	125	4,664
Project 4	3,248	-	-	-	3,248
Project 5	115	574	1,180	1,244	3,113
Project 6	-	514	1,710	823	3,047
Project 7	342	984	31	1,123	2,480
Project 8	489	873	528	466	2,356
Project 9	842	838	5	-	1,685
Project 10	526	578	499	-	1,603
All others (187)	13,661	13,022	12,275	10,004	48,962
Total project costs	**$27,622**	**$28,806**	**$27,005**	**$17,864**	**$101,297**

Source: Financial Management Information System

During the period of our review, the top 10 projects each had total costs ranging from $1.6 million to $25.3 million. Total project costs amounted to $101.3 million during the four year period of our review. These amounts do not include costs pertaining to projects that began prior to the period of our review, nor do they include estimates of costs that are left to be incurred on projects that were not yet completed.

OCIO policy requires that at the beginning of each budget planning cycle, each department provides the OCIO with a prioritized list of projects that they would like to have considered. Based on OCIO analysis of these projects identified by departments, a preliminary listing of projects for the upcoming fiscal year is compiled by the OCIO and is then presented for funding consideration during the budget process.

Funding for these projects is allocated from either the annual base funding within the OCIO budget or through additional funding received for specific projects.

Departments may also fund projects that are managed by the OCIO. These projects were not included in the scope of our review.

In April 2011, the OCIO entered into long-term contracts with three external vendors, collectively termed the Consortium, for information technology and information management professional services. These contracts covered the period April 2011 to March 2014, and were extended in July 2013 for an additional two fiscal years.

When there is a need for professional services for a project, the work is required to be offered to one of the external vendors within the Consortium, depending on their unique abilities and availability to complete a particular project. A Project Opportunity document (PRO) is completed and provided to these vendors only for work that could be completed by more than one of the vendors within the Consortium. This document is similar to a request for proposal, which is a required part of a competitive process.

When a Consortium consultant is assigned a new piece of work, a signed Statement of Work becomes the agreed upon work for that project. Statements of Work are completed on a fiscal year basis and are typically completed for each phase of a project or smaller portions of work, and include expected costs for that portion of the project.

If the project requires the acquisition of established software or software and professional services, Government policy requires a Request for Proposal (RFP) to be prepared in accordance with the *Public Tender Act* (*PTA*) or the Government's *Guidelines Covering the Hiring of External Consultants* (Consultant Guidelines), as applicable. This RFP is issued externally and is available for bid by vendors within the Consortium as well as vendors not in the Consortium.

When an RFP is awarded to a vendor outside the Consortium, a contract between the vendor and the OCIO becomes the agreed-upon work for that project and describes expected costs. Statements of Work are also completed for each phase of the project or smaller portions of work and describe in more detail the work to be performed.

Our review indicated the following:

Budgeting

Given the size and complexity of projects undertaken by the OCIO, we would expect to see an overall cost and timeline budget for each project prior to the commencement of the work. We would expect to see an allocation of the cost and timeline of the budget across the phases of the project, particularly for larger, multi-year projects. We would expect to see monitoring and re-forecasting of the overall project costs and timeline throughout the life of the project with comparison against original budget details. Upon completion of a project, we would also expect to see a final analysis that provides comparison of the original budget to the actual costs and timelines and detailed explanations of the variances. Much of this information would be tracked in an automated system given the size of the projects.

As part of our review, we chose a sample of five projects from 197 projects overseen by the Solutions Delivery Branch that had been substantially completed during the scope period of our review. The costs incurred during the four fiscal years of our review for the projects chosen for our review ranged from $0.6 million to $25.3 million.

OCIO officials provided us with project tracking spreadsheets that showed, for each fiscal year, the funds allocated to each project based on anticipated expenditures for the fiscal year. Each month, actual costs and expected costs were compared to the annual budgeted amount.

Four of the five projects we reviewed had reached final completion within the period of our review and spanned multiple years of the scope period of our review. OCIO officials were unable to provide evidence that the cost of the projects had been tracked over multiple fiscal years or that a final analysis of the projects had included a comparison of the total final costs and timelines of the project to the overall budgeted amounts and timelines.

Though the OCIO ensures that projects do not exceed their annual allocation of funds, there was no evidence of consideration of funds already spent on the project, or funds needed to complete the project. Over multiple fiscal years, the OCIO does not have processes in place to identify projects that are over budget, in either time or cost. As a result, multi-year projects may accumulate total costs that are significantly beyond what was originally expected, with no analysis and reporting of any variances between the originally approved budget and actual costs and no documented reasons for the overages.

We also determined that the OCIO was using various excel spreadsheets for annual project tracking and monitoring against funds allocated. The spreadsheets were manually updated. Reliance on spreadsheets and manual updating to this extent increases the risk of error and issues not being identified in a timely manner.

Findings

1. The OCIO was not able to demonstrate that during the scope period of our review project costs and timelines were being monitored over multiple fiscal years against an overall budget. As a result, multi-year projects may accumulate total costs that are significantly beyond what was originally expected, with no analysis and reporting of any variances between the originally approved budget and actual costs and no documented reasons for the overages.

2. During the scope period of our review, the OCIO was using spreadsheets for annual project tracking and monitoring against funds allocated, which were manually updated. This reliance on spreadsheets and manual updating increased the risk of error and issues not being identified in a timely manner.

Statements of Work

For each phase or portion of work within a project that requires professional services, a new Statement of Work is created. OCIO policy states that the Statements of Work *"set out in more precise detail the exact services and the deliverables to be provided by the Vendor,"* as well as expected and approved costs.

OCIO policy requires that change requests are prepared to allow a cost or timeline change to an approved Statement of Work. These changes may include, for example, a change to the budget, timeline or deliverables. Change requests require a detailed explanation and must be approved by both the OCIO and the consultant.

We reviewed all 60 Statements of Work within the five projects we reviewed. Of the 60 Statements of Work we reviewed, there were 28 that had one or more change requests. There was a total of 44 approved change requests associated with the 28 Statements of Work, within which there were 37 instances where there was an increase in costs and 24 instances where there were time extensions.

Table 3 provides details of the 10 Statements of Work that had the largest total dollar change requests within the 28 Statements of Work we reviewed that had an associated change request.

Table 3

Office of the Chief Information Officer
Change Requests within Statements of Work Reviewed
During the Period April 2010 to March 2014

Statement of Work (SOW)	Original Approved Value	Value of Change Requests (CR)	% Increase	Total Revised Value	Original Timeline	Final Timeline
A	$280,000	$890,034	317.87%	$1,170,034	April to June 2010	Extension to March 2011
B	733,725	517,969	70.59%	1,251,694	April to July 2011	Extension to March 2012
C	163,220	297,453	182.24%	460,673	July to December 2012	Extension to March 2013
D	202,177	277,524	137.27%	479,701	April to July 2011	Extension to March 2012
E	75,390	148,420	196.87%	223,810	April to June 2012	Extension to March 2013
F	107,615	137,895	128.14%	245,510	September to November 2010	Extension to March 2011
G	50,400	121,200	240.48%	171,600	June to August 2012	Extension to March 2013
H	184,236	107,454	58.32%	291,690	June 2010 to March 2011	No time extension
I	780,800	99,015	12.68%	879,815	April 2012 to March 2013	No time extension
J	956,700	90,474	9.46%	1,047,174	April 2013 to March 2014	No time extension
Total SOW with Largest CR	**$3,534,263**	**$2,687,438**	**76.04%**	**$6,221,701**		
All Other SOW with CR	4,463,353	130,194	2.92%	4,593,547	Various	Various
Total SOW with CR	**$7,997,616**	**$2,817,632**	**35.23%**	**$10,815,248**		

Source: Office of the Chief Information Officer

As shown in Table 3, 10 Statements of Work with original approved values of $3.5 million had change requests totaling $2.7 million, a 76% increase from the original value.

As also shown in Table 3, total change requests for Statement of Work A resulted in the revised value increasing by more than 300%. There were others, such as Statement of Work C, that resulted in a revised total value that was more than double the original Statement of Work value.

Statement of Work A also had a significant increase in time using change requests by extending the Statement of Work date from an original three month Statement of Work to become a one year term, four times longer than the issued Statement of Work. Similarly, Statement of Work C used a total of three change requests to extend the original Statement of Work from a five month term to an eight month term.

The OCIO Project Management Reference Guide (Project Reference Guide) states that: "*minimizing the number of change requests can be achieved by defining the scope of the project with the project sponsor upfront. It is important to identify what is in scope as well as what is out of scope. A well planned project with a realistic schedule and budget and a signed project charter will also minimize the number of change requests.*"

In some instances, change requests were not being used to initiate a change to the original Statement of Work, but were instead being used to approve new work. For example, in one case, the purpose of the original Statement of Work was to complete planning activities for the project. There were three change requests approved related to this particular Statement of Work. The change requests provided approval for the consultant to continue with activities that were beyond the planning phase of the project. In this case, a new Statement of Work should have been prepared to ensure the details of the exact services and deliverables to be provided by the vendor were agreed upon.

Findings

3. The volume and costs of change requests associated with the Statements of Work we reviewed were significant, with one Statement of Work having change requests of more than 300% of the value of the original Statement of Work.

4. Some of the change requests we reviewed were being used to approve significant additional work, rather than being used to only initiate a change to the original Statement of Work.

Project Performance Monitoring

OCIO policy requires the establishment of a steering committee for each project. The steering committee must include, at a minimum, the designated project sponsor from the department, the Delivery Manager and the Project Manager. This committee generally meets on a monthly basis during the life of the project to discuss the status of the projects, issues, risks and other relevant items.

During our review of a sample of five projects that had been completed during the period April 2010 to March 2014, we obtained copies of steering committee minutes of all five projects. We expected that each steering committee meeting would have the required members in attendance and that there would be a detailed discussion of project status and current issues.

In 31 of the 73 steering committee minutes reviewed, we found that the Delivery Manager was not present as required by OCIO policy. We did however find that there was appropriate discussions of project status and current issues.

Findings

5. For the five projects we reviewed, the project steering committee meetings were not all attended by the required personnel.

6. For the five projects we reviewed, steering committee meetings included appropriate discussions of project status and current issues.

1B. System Development Life Cycle Methodology

Introduction

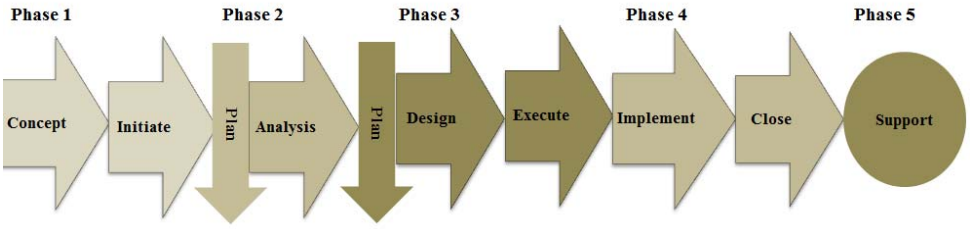
The SDLC methodology is comprised of a number of clearly defined and distinct work phases which are used by systems engineers and systems developers to plan, design, build, test and deliver information systems. The OCIO uses this methodology in its delivery of information technology solutions to entities it supports.

The Project Reference Guide provides guidance on the administration of the SDLC methodology. The Project Reference Guide states that: "*A deliverable is not considered complete until all required approvals have been obtained...*".

The SDLC methodology is composed of five phases as shown in Figure 2.

Figure 2

Office of the Chief Information Officer
System Development Life Cycle



Source: Office of the Chief Information Officer

As at September 30, 2014, there were 58 SDLC core documents, also called deliverables, comprising components of the methodology. These deliverables are to be completed as necessary. The parameters of a project, through a deliverables matrix, determines whether a particular deliverable is required for a project.

The deliverables matrix is used by the OCIO when applying the SDLC methodology to a project. There is a deliverables matrix for each of the SDLC core documents that identifies each deliverable as mandatory, optional or not applicable depending on the project type and size.

Project types have a broad range of categories, including, for example, infrastructure and enhancement. The project sizes are defined within parameters ranging between extra-small and extra-large. Each of the project size and project type parameters are defined in detail within the SDLC methodology. Therefore, for example, a testing strategy is considered optional for a small sized project and mandatory for a large project, but non-applicable for infrastructure-type projects.

As part of our review, we chose a sample of five projects from a population of 197 overseen by the Solutions Delivery Branch that had been substantially completed during the scope period of our review. Table 4 provides the project costs incurred during the period of our review for each of the five projects we reviewed. The projects were chosen based on the dollars spent on the project as well as the timeframe in which the project was completed.

Table 4

Office of the Chief Information Officer
Project Expenditures
Between April 1, 2010 and March 31, 2014

Project	Costs
Project A	$25,329,600
Project B	4,808,715
Project C	3,047,071
Project D	1,066,789
Project E	560,683

Source: Office of the Chief Information Officer

We expected that all required documentation within each phase of the SDLC methodology would be completed and contain evidence of proper approvals as required by the Project Reference Guide.

Our review indicated the following:

Project Management Guidance

There are many stakeholders involved in the development of a new system for Government. The requirements and development of these new systems are complex in nature and require extensive processes in order to be completed effectively.

The mission of the PMO is "*to further the understanding of Project Management, deliver successful methodology, encourage professional development, create the professional tools needed for successful Project Management, and promote the need for continuous improvement*".

During our review, we expected to see evidence of the PMO's guidance in using the SDLC and the creation of tools to be used to assist in implementing the guidance. During our review, we determined that the SDLC methodology guidance was current, having been last updated in March of 2014.

The Project Reference Guide is also available to project managers and other personnel involved in the management of a Solutions Delivery project. The Project Reference Guide provides information related to the structure of the OCIO, its methodology, contacts and project administration.

The Project Reference Guide was last updated in September 2014 and appeared to be up-to-date in all material respects.

Finding

7. Based on our review of the OCIO Project Reference Guide, there was appropriate guidance available for the technical requirements of projects and the guidance was up-to-date.

SDLC Methodology

Phase 1 - Concept and Initiate

The first phase of the SDLC methodology is the Concept and Initiate Phase. All deliverables outlined in the deliverables matrix, that defines which documents are necessary, are required during this phase, regardless of project type and size. The creation of a Business Case is required to be completed by the Solutions Delivery Branch upon receiving a project request from a department. The Business Case requires summarization of the business problem that a new system would be expected to resolve, the objectives and expected benefits of the new system, as well as the risks of not proceeding with a solution. A Preliminary Scope is also required to be prepared, which identifies the expected users, stakeholders and required functionalities of the project. Assumptions and constraints that have an impact on the development of a project are required to be listed in this document. It is within this phase that the size of the project is determined and documented.

Phase 2 - Plan and Analysis

The second phase of the SDLC methodology is the Plan and Analysis phase. In the Planning stage of the phase, a detailed plan is prepared using a Project Charter. The Project Charter determines and documents the employees involved in the management of the project including the Project Manager, Delivery Manager, Director and a sponsor at the requesting department (the Client). Required client resources and required OCIO resources are identified at this stage, as well as key risks and issues. A high-level funding estimate for the remaining phases of the project is also required to be determined and documented in the Project Charter. Checklists are utilized to document any information management and privacy concerns that may exist within a particular project.

In the Analysis stage of the phase, an in-depth analysis is required to be performed to obtain a detailed understanding of the business needs as defined in the Business Case and Preliminary Scope documents. Together, the Client and Solutions Delivery employees on the Project Team are required to prepare a Financial Management and Business Process Definition document which must explain all current business processes relevant to the new system being implemented, as well as considerations if the system is to be used in multiple locations. A Business Requirements document is required to detail the needs of the project, including business, regulatory and functional requirements. A listing of technical requirements for a new system to be developed, if applicable, is also required to be prepared at this stage.

Phase 3 - Plan, Design and Execute

In the Planning stage of Phase 3, detailed planning is required, and the validation of the detailed plan against the previously approved Business Case is required. In the Design stage, a detailed description is required of how the proposed solution is to be developed. This stage is very technical and results in a Detailed Architecture Design document to determine the technical suitability of a project's architectural design, and is reviewed for adherence to the OCIO technical standards and standards regarding stability, availability and security. The Execution stage of Phase 3 requires the development, configuration and testing of the proposed solution.

Phase 4 - Implement and Close

The fourth phase of the SDLC methodology is the Implement and Close phase. In the Implement stage, the developed/configured solution is required to be implemented. The system is required to be installed and made operational. Application Quality Assurance Checklists are required to be completed for custom-built applications. Disaster Recovery Plans are to be prepared and a Go Live Communication document is required to ensure all project stakeholders are aware of critical dates. The Go Live Communication document is to outline the details of the stabilization period, which is an agreed-upon timeframe in which the Project Team retains control of the solution to ensure major bugs and issues are resolved. The Go Live Communication is also required to outline the details of the transition period, which is the timeframe in which knowledge transfer from the Project Team to the OCIO support teams in Application Services and Operations is to occur.

In the Close stage, all activities necessary to close out the project, including, for example, the required closing of contracts and vendor evaluations, are to be performed. A Project Closure Report is to be prepared, which compares actual project costs to budgeted costs and timelines, lessons learned and best practices. The Closure Report document confirms handover of the project from the Project Team to Application Services and Operations.

Phase 5 - Support

The last Phase is the Support stage. This stage requires the on-going support and maintenance of the implemented solution. The Application Services and Operations branches are responsible for the project at this stage. There are no SDLC methodology deliverables required for this stage.

For the five projects we reviewed, we compared the completed SDLC core documents to the requirements of the SDLC methodology and the deliverables matrix. We reviewed the deliverables in detail and ensured they contained a sufficient amount of detail to adequately achieve the intended purpose of the document. We also examined the deliverables to ensure they had been properly approved.

Table 5 provides a summary of our review of the documents required in each phase, for each of the five projects reviewed.

Table 5

Office of the Chief Information Officer
Documents required for each phase of the SDLC Methodology
For Five Projects Reviewed

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Project A	✓	✓	✓	Inc	N/A
Project B	✓	✓	✓	✓	N/A
Project C	✓	✓	✓	✓	N/A
Project D	X	*	N/A	N/A	N/A
Project E	✓	✓	✓	✓	N/A

✓ - All Required Documents Completed
X - Documents not Completed
* - Documents not Warranted in Context
N/A - No Documents Required
Inc - Incomplete as project is not yet at this stage

As outlined in Table 5, for four of the five projects we reviewed, all required documents were completed. We reviewed the required documents and they contained a sufficient amount of detail to adequately achieve the intended purpose of the document. However, we did not find evidence of proper approval in 11 of 73 deliverables documents we reviewed.

Also, for one of the four Closure Reports we reviewed in Phase 4 of the SDLC methodology, the actual costs detailed were inaccurate.

For project D, the required deliverables were not fully completed for any of the phases of the methodology. Discussions with OCIO officials indicated that it had been determined that the context of the particular project did not warrant those documents. However, SDLC methodology indicates that all documents within the methodology are required. We evaluated the purpose and the relevance of each of the missing documents to the required deliverables in the methodology for this project and believe that there would have been value in the completion of the deliverables in Phase 1, in that the deliverables require the documentation of the business purpose for completing the project.

After reviewing the reason for not completing the deliverables in Phase 2 of the project, we agree that the deliverables would not have provided any value, however, the methodology does not allow for this.

The size assigned to a project determines whether certain deliverables are mandatory, optional or not applicable. Discussions with OCIO officials indicated that the PMO had developed a project sizing calculator which takes into account *"a number of dimensions that relate to the level or degree of risk, the strategic value, visibility, the technical requirements, total project cost and other key factors"*. However, the project calculator was never utilized within the projects.

Discussions with OCIO officials indicated that the size of each project is determined through discussions with various stakeholders. Therefore, in some instances, deliverables that may have been required were not completed resulting in possible oversights in planning or execution of a project. In other instances, more documents were completed, which took additional time and cost than what was necessary.

During our review, we also found that the rationale for determining the size of each project was not documented for each of the five projects reviewed.

Findings

8. We did not find evidence of proper approval in 11 of 73 deliverables documents we reviewed.

9. For one of the projects we reviewed, the actual costs detailed in the Closure Report were inaccurate.

10. In one of the five projects reviewed, the documents required by SDLC methodology within Phases 1 and 2 of the project had not been completed as required. Our review determined that there would have been value in completing the documents for Phase 1 in that the purpose and relevance of completing the project would have been evident.

11. A project sizing calculator that was available for use during the scope period of our review was not being utilized when determining the size of projects. Therefore, all relevant dimensions of a project may not have been taken into consideration, which would affect the documentation required.

1C. Administration of Projects

Introduction

During the year ended March 31, 2014, the OCIO spent $17.9 million (2013- $29.2 million) on professional services. Professional services expenditures are comprised of costs pertaining to the acquisition of professional services for development projects and operational needs. The Solutions Delivery Branch is responsible for the procurement of professional services required for a system development project. The Operations Branch is responsible for the procurement of professional services required for operational needs.

To acquire professional services, the OCIO must comply with the requirements of the *PTA* and the Consultant Guidelines.

Once an external consultant is chosen for a particular project, the OCIO must prepare a Work Offer, which outlines the work requirements and the proposed timeline for completion.

The external consultant must then prepare a Statement of Work which describes, in detail, the work that they intend to perform, expected costs, including travel, and timelines. The Statement of Work must then be submitted to the OCIO. OCIO policy requires the Statement of Work to be reviewed and approved by the Project Manager, the Delivery Manager, the Director and the Executive Director of the Solutions Delivery Branch. The Chief Information Officer (CIO) is required to review and approve certain Statements of Work, depending on thresholds outlined in OCIO policy. Upon review and approval by all required individuals, a purchase order (PO) is created and the vendor can begin the work described in the Statement of Work.

Work Offers and Statements of Work are required to be prepared on a fiscal year basis. OCIO policy also allows Work Offers and Statements of Work to be prepared for each portion of work to allow efficiencies in the preparation of these documents across more than one fiscal year. A Work Offer and Statement of Work must be prepared for each vendor when there are multiple vendors involved in a project.

Our review indicated the following:

Selection of Vendor

In instances in which an RFP or a PRO is required as part of a project, a formal evaluation of the proposals received is to be completed. This evaluation requirement is the same for PROs issued to the vendors within the Consortium and RFPs issued and available for response by all interested vendors. The Consultant Guidelines outline factors that must be considered when selecting an external consultant, such as:

- Qualifications, background and experience of the vendor;
- Level of performance displayed by the external consultant in previous work of a similar nature and size; and
- Quality of the required study plan submitted in terms of logic, method of approach and comprehensiveness.

In cases where two or more vendors are deemed qualified in capacity to complete a specific project, the selected consultant should be the lower priced proposal.

During our review, we would have expected that all relevant requirements within the Consultant Guidelines had been appropriately addressed.

Of the five projects reviewed, two projects required either an RFP or a PRO for a portion of the project execution. We reviewed all supporting documentation held by the OCIO regarding the RFPs or PROs for the two projects. We determined that an Evaluation Report was prepared by an Evaluation Committee, consisting of members of the OCIO and the department to which the project related. The supporting documentation showed that each proposal received had been appropriately evaluated against predetermined criteria. An evaluation matrix had also been completed for both projects. Both projects had been awarded to the vendor with the highest score.

The two evaluations we reviewed demonstrated that the requirement of the Consultant Guidelines had been followed.

Finding

12. The OCIO complied with the Consultant Guidelines in the evaluation and awarding of contracts, as required, within the five projects we reviewed for which RFPs or Project Opportunity documents had been issued.

Approval of Work

In instances in which an external consultant is required to provide services for a project, the details agreed to within a Statement of Work between the OCIO and the vendor are critical to the success of the project.

We reviewed all 60 Work Offers and the associated Statements of Work related to the five projects reviewed. Of those, we found 37 instances where work was conducted by the vendor before all the proper authorizations were obtained by the OCIO. In one instance, the vendor had already completed four weeks of work, and had invoices totaling $109,092, before the OCIO approved the Statement of Work submitted by the vendor.

In another instance, work had been started and invoiced by the vendor before a Work Offer was made to the vendor. The vendor therefore started work on a project piece for which they had not received approval. The vendor received a Work Offer four days after the work had begun, and the Statement of Work was approved 10 days after the work had begun.

If there had been disagreements in the Statement of Work between what the vendor intended to perform and the work that the OCIO was expecting, it may have been too late for the OCIO to request different work from the vendor, as they already in some instances had many weeks of work completed.

Finding

13. Within the 60 Work Offers we reviewed, there were 37 instances in which work performed by vendors was started and invoiced to the OCIO before the work was offered and/or approved.

Invoices

Vendors provide monthly invoices to the OCIO for professional services performed on projects. These invoices are required to be reviewed by the OCIO for accuracy and are required to be coded so that they can be accounted for properly in the Government's Financial Management System.

Some Statements of Work with vendors also allow for travel expenses that are paid in accordance with Government policy. The OCIO provides a vendor with a summary of Government travel policies, which includes an itemized list of what can and cannot be claimed as a travel expense, as well as what support should be provided. All receipts are required to be submitted and validated by the OCIO before they are reimbursed.

We reviewed a sample of 60 invoices totaling $5.2 million provided by vendors for professional services, to ensure they were appropriately approved and coded correctly. In all instances, the appropriate approvals were present. Also, in all instances, the invoices were correctly coded to the proper account.

We also reviewed a sample of 30 vendor invoices that included travel costs totaling $1.6 million. We identified the following issues:

- 81% ($1.3 million) of the travel costs in our samples were not supported by receipts including flights, hotels and taxis. Only four out of 30 travel invoices were fully supported. Also, in one instance, the vendor listed $21,717 as miscellaneous expenses with no support.

- 20 of 30 travel invoices, all from one particular vendor, contained expenses that were inconsistent with contract provisions yet were fully reimbursed without receipts to support such a charge. For instance, a number of individuals had both taxi and car rental costs, or taxi costs and parking costs. On one project, expenses in February 2011 included both car rental and taxi expenses for each of three individuals. These three individuals, over the course of one month, incurred total car rental expenses of $1,760 and taxi costs of $1,487. Even though we would expect some taxi costs, for example to get from the airport to their home, these charges appeared unreasonably high. Since receipts were not provided, we were unable to validate whether these expenses were legitimate.

At the time of our review, the OCIO was undergoing their own review of practices related to the payment of travel invoices. In particular, they were investigating payments made to the above noted vendor by requesting all supporting receipts, and reviewing for adherence to Government policies. Issues have been identified with travel not being in accordance with Government policies, and the OCIO are now in the process of recovering these funds.

Findings

14. For the 60 invoices we reviewed, fees for professional services were appropriately approved.

15. Within the 30 invoices we reviewed that included travel costs, the OCIO was not validating travel expenses before the vendor invoices were paid. Often, travel expenses were unsupported and some appeared to be inconsistent with the contract provisions. These unsupported travel expenses are currently being investigated by the OCIO and possible recoveries may be realized.

2. Use of Resources

Objective

To determine whether the OCIO was using its resources effectively in meeting its mandate.

Conclusion

We determined that the OCIO was not always utilizing its resources effectively in meeting its mandate. Though the OCIO had achieved savings through the creation of certain new salaried positions to replace the hiring of external consultants, there were still positions being filled by external consultants for multiple projects over multiple years that were, in effect, full-time roles that could have been filled by internal employees at a lower cost.

Overview

As at March 31, 2014, the OCIO had 323 employees within its four branches. Approximately 245 (76%) employees worked in technical positions; the remaining 81 (24%) employees worked in management, executive, administrative or technology support positions. The technical positions exist within both operations and projects. Of the 245 employees in technical positions, 47 employees were working full-time on projects within the Solutions Delivery Branch and 198 employees were operational.

During the year ended March 31, 2014, the OCIO employed 205 external consultants on a contractual basis to supplement permanent employees. Of these, 173 were contracted for projects and 32 for operations. The average time worked in a contracted position by external consultants for the year ended March 31, 2014 was six months.

Table 6 shows the composition of expenditures for the fiscal years under review.

Table 6

Office of the Chief Information Officer
Expenditures
For the Years Ended March 31
($000's)

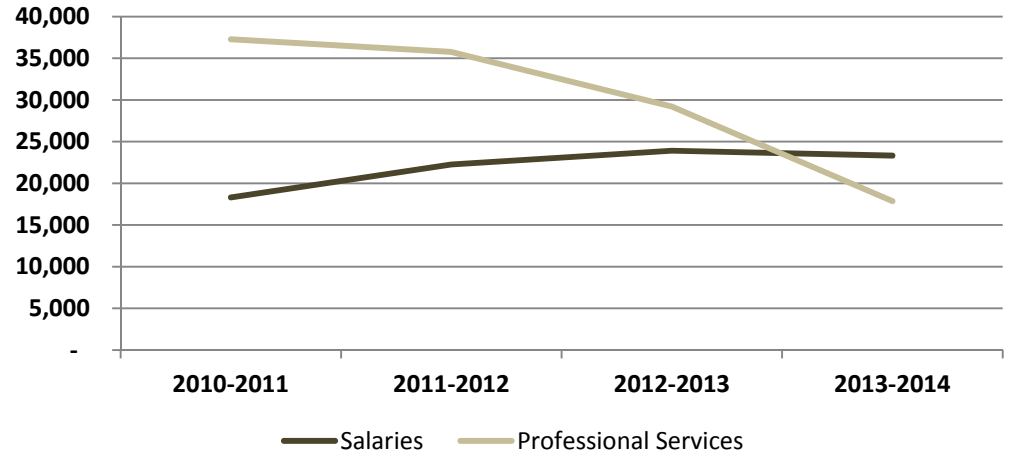
	2011	2012	2013	2014
Professional Services	$37,280	$35,749	$29,206	$17,857
Salaries	18,301	22,262	23,919	23,313
Supplies	12,412	9,999	10,317	9,401
Property, Furnishings and Equipment	6,334	4,738	3,933	3,954
Purchased Services	4,505	4,879	4,692	5,599
Transportation and Communications	3,548	2,933	3,533	2,585
Employee Benefits	38	40	27	27
Total Expenditures	**$82,418**	**$80,600**	**$75,627**	**$62,736**

Source: Department of Finance, Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

Within the scope period of our review, total professional services cost for the OCIO decreased 52%, from $37.3 million in 2010-11 to $17.9 million in 2013-14. During the same period, salaries increased 27%, from $18.3 million to $23.3 million. Figure 3 depicts these trends.

Figure 3

Office of the Chief Information Officer
Professional Services and Salaries Expenditures
For the Years Ended March 31
($000's)



Source: Office of the Chief Information Officer

The Solutions Delivery Branch incurred the majority of professional services costs during each of the fiscal years of our review, while the Operations and Applications Services Branches incurred greater portions of total salary expenditures. This is a result of the extensive use of contract individuals for projects.

As part of its mandate, the OCIO works collaboratively with the private information technology industry to deliver information technology and information management solutions. The OCIO has a mandate of "*working collaboratively with the private information technology sector to maximize business opportunities while meeting the Information Technology and Information Management needs of Government*."

While this mandate must be met, the OCIO has an obligation to utilize its budgetary resources in a fiscally prudent manner. This includes achieving an appropriate balance between salaries and professional services costs.

Our review indicated the following:

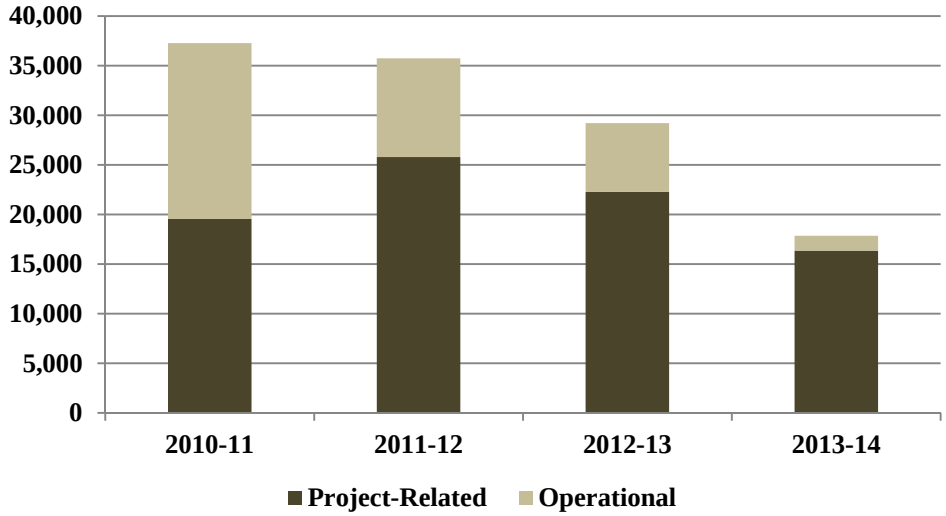
Use of Internal versus External Resources

During the fiscal year ended March 31, 2010, the OCIO proposed and obtained approval for the creation of 81 new permanent positions within its internal organizational structure to, primarily, replace contracted external consultants. It was estimated by OCIO that these new positions would generate savings of approximately $9.2 million per year.

A total of 57 of these approved positions were filled during the fiscal years ended March 31, 2012 and March 31, 2013. The positions filled during the fiscal year ended March 31, 2012 resulted in annual savings to Government of $3.0 million, while the positions filled during the fiscal year ended March 31, 2013 achieved $2.6 million in annual savings. The combined annual savings for these 57 positions was $5.6 million. Approximately 88% of the annual savings were a result of savings in operational positions while the remainder was project resource related. The impact of the creation and filling of internal positions and decrease in related professional services costs can be seen in Figure 4.

Figure 4

Office of the Chief Information Officer
Professional Services Costs - Operational and Project-Related
For the Years Ended March 31
($000's)



Source: Office of the Chief Information Officer

For the year ended March 31, 2010, total professional services costs were $37.3 million. Professional services costs related to operations were $17.7 million, or 47% of the total professional services costs. For the year ended March 31, 2014, total professional services costs were $17.9 million. Professional services costs attributable to operations had decreased to $1.5 million, or 8% of total professional services costs.

Finding

16. During the scope period of our review, the OCIO had achieved annual cost savings of $5.6 million through the creation of new salaried positions to replace the hiring of external consultants.

Opportunity for Further Savings

Internal Hiring

For the year ended March 31, 2014, it was estimated that the remaining 21 of the original 81 positions requested and approved during the fiscal year ended March 31, 2010 would have generated additional annual savings of $2.4 million to Government. Three of the 81 positions were eliminated due to management attrition.

For fifteen of these positions, either qualified candidates had been identified or potential candidates were going through the interview process. During the years ended March 31, 2012 and March 31, 2013, these 21 remaining positions were eliminated from the organizational structure of the OCIO as a result of budgetary restraint measures.

We found that external consultants continued to fill eight of these positions during the year ended March 31, 2014. Therefore, as a result of the decision to cut the positions before they had been filled, external consultants remained in at least eight positions for which the OCIO had recognized an opportunity for cost savings.

Use of External Consultants

Professional services costs were reduced significantly during the scope period of our review, decreasing from $37.3 million in 2010-11 to $17.9 million in 2013-14, a reduction of $19.4 million, or 52.0%. However, professional services costs of $17.9 million for the year ended March 31, 2014, were still significant and represented 28.5% of OCIO's actual expenditures for the year.

During our review, we reasonably expected to see instances in which external consultants were utilized to provide staffing on projects that were larger in scope and for which there was not enough internal staff to fill the staffing requirements. We also expected to see instances in which external consultants were utilized to provide staffing for relatively short periods of time to cover staffing needs in which there were instances of a higher volume of short-term projects for which it was not feasible to hire internally.

Table 7 shows the details of external consultants who worked on multiple projects for two or more consecutive years.

Table 7

Office of the Chief Information Officer
Consultants Working on Multiple Projects for Two or More Consecutive Years
For the period April 2010 to March 2014

	Number of Consultants by Quantity of Projects				
Number of Consecutive Years	**2 Projects**	**3 Projects**	**4 Projects**	**5+ Projects**	**Number of Consultants per Consecutive Year Category**
2	23	16	11	13	63
3	9	12	5	7	33
4	3	3	2	2	10
Total	**35**	**31**	**18**	**22**	**106**

Source: Office of the Chief Information Officer

We found that 106 external consultants had worked for two or more consecutive years on more than one project during the scope period of our review. Five position types, in particular, were filled throughout the scope period of our review by 57 of the 106 consultants (54%). The roles performed by these external consultants were, in effect, full-time roles for which internal positions would have resulted in a lower cost.

The total cost of these 106 external consultants for the period under review was $40 million. This represents 33% of the total professional services costs of $120 million over the scope period of our review. The savings which would have been realized if these 106 consultants were hired as employees instead of external consultants is approximately $21.6 million over four years.

As can be seen in Table 7, there were 10 external consultants who worked for four consecutive years on two or more projects during the scope period of our review. The total cost for these four years was approximately $8,544,000. As salaried employees they would have been paid approximately $3,761,500 for the same time period, which would have generated a savings of $4,782,500 for the four years under review.

Finding

17. During the period of our review, external consultants remained in at least eight positions for which the OCIO had recognized an opportunity for cost savings through new, approved salaried positions. These positions were within a group of 21 approved salaried positions that were eliminated as a result of budgetary restraint measures.

18. There were 106 external consultants that had worked for two or more consecutive years on more than one project during the scope period of our review. Five position types, in particular, were filled throughout the scope period of our review by 57 of the 106 consultants (54%). The roles performed by these external consultants were, in effect, full-time roles for which internal positions would have resulted in a lower cost.

Recommendations

1. The OCIO should ensure that project costs and timelines are being monitored and documented over multiple fiscal years against an overall budget, and that a process is in place to identify projects that are over budget, in either cost or time.

2. The OCIO should ensure that there is an adequate system in place to monitor project costs.

3. The OCIO should ensure that the level of detail within a Statement of Work is appropriately considered to reduce the need for change requests and the OCIO should carefully consider the circumstances surrounding additional work to determine whether it is more appropriate to prepare a new Statement of Work or a change request. The OCIO may also wish to develop a policy to guide the decision whether a new Statement of Work is required.

4. The OCIO should ensure that project steering committee meetings are attended by all required personnel.

5. The OCIO should ensure that the actual costs detailed in the Phase 4 Closure Report of the SDLC methodology are accurate.

6. The OCIO should ensure that all documents required by SDLC methodology are completed and approved as required and should utilize the project sizing calculator when determining the size of projects.

7. The OCIO should ensure that work is not begun by vendors prior to the completion and approval of a Work Offer.

8. The OCIO should ensure that vendor travel costs are validated against supporting details before an invoice is paid.

9. The OCIO should consider the potential for cost savings through the hiring of Government employees in the place of select external consultants.

OCIO Response

1. ***The OCIO should ensure that project costs and timelines are being monitored and documented over multiple fiscal years against all overall budget, and that a process is in place to identify projects that are over budget, in either cost or time.***

   Response:
   The OCIO agrees with the Auditor General on the importance of monitoring and documenting project costs over multiple fiscal years. The OCIO does track fiscal year-over-year spending on large multi-year projects and all projects are subject to monthly monitoring as part of Government's overall budget monitoring process. Often projects are budgeted by phase or piece of work and the overall total of the combined phases is not tracked in the way noted by the Auditor General. However, Government's financial system is used to provide a full picture of spending in all projects and phases.

   The OCIO accepts the recommendation of the Auditor General and will review its process and documentation.

2. ***The OCIO should ensure that there is an adequate system in place to monitor project costs.***

   Response:
   The OCIO acknowledges the Auditor General's recommendations. The OCIO has been reviewing its processes with an aim to improve tracking and monitoring.

3. ***The OCIO should ensure that the level of detail within a Statement of Work is appropriately considered to reduce the need for change requests and the OCIO should carefully consider the circumstances surrounding additional work to determine whether it is more appropriate to prepare a new Statement of Work or a change request. The OCIO may also wish to develop a policy to guide the decision whether a new Statement of Work is required.***

   Response:
   The OCIO acknowledges the importance of ensuring adequate detail is included in each Statement of Work and continuously works to improve the process of finalizing all requirements before a Statement of Work is issued.

   The OCIO is committed to developing clear guidance as to when a change request or a Statement of Work is required.

4. ***The OCIO should ensure that project steering committee meetings are attended by all required personnel.***

   Response:
   The OCIO agrees with the Auditor General's recommendations and will continue to ensure that an appropriate person attends these meetings on behalf of the sponsoring Department and the OCIO. There will be times when not all people can attend due to scheduling conflicts and other priorities but the OCIO will continue to ensure the right people are in attendance to ensure the required decisions are made.

5. ***The OCIO should ensure that the actual costs detailed in the Phase 4 Closure Report of the SDLC methodology are accurate.***

   Response:
   The OCIO agrees and will ensure this occurs in future.

6. ***The OCIO should ensure that all documents required by SDLC methodology are completed and approved as required and should utilize the project sizing calculator when determining the size of projects.***

   Response:
   The OCIO agrees with the Auditor General's recommendation re ensuring that all documents are completed and approved as required by the SDLC. It is important to note that the SDLC methodology is regularly reviewed and updated to ensure appropriate steps are followed in delivery of projects. The OCIO notes that the project sizing calculator is an optional tool in the methodology and was designed to provide sizing for standard build type projects, but not necessarily for infrastructure related projects. OCIO commits to reviewing the sizing calculator and ensuring it is used on appropriate projects.

7. ***The OCIO should ensure that work is not begun by vendors prior to the completion and approval of a Work Offer.***

   Response:
   The OCIO agrees with the Auditor General's recommendation and has recently implemented a requirement to ensure that no resources start work until Statements of Work are approved. We do note that the Work Offer is now combined with the Statement of Work into one Statement of Work document.

8. ***The OCIO should ensure that vendor travel costs are validated against supporting details before an invoice is paid.***

   Response:
   The OCIO acknowledges that the practice of using random audits rather than full detail review for travel invoices should be changed, and has since modified its practices to ensure that all supporting details are provided and reviewed before an invoice is paid.

9. The OCIO should consider the potential for cost savings through the hiring of Government employees in the place of select external consultants.

Response:
The OCIO will continue to identify and pursue opportunities to replace contractual positions with internal positions. It is important to note, the OCIO cannot recruit without the Government authority to do so and cannot always attract resources with specific technology skills at the compensation and terms of employment offered.

PART 3.5

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

NEWFOUNDLAND AND LABRADOR PRESCRIPTION DRUG PROGRAM

Summary

Introduction

The Pharmaceutical Services Division (the Division) of the Department of Health and Community Services (the Department) is responsible for operating the Newfoundland and Labrador Prescription Drug Program (NLPDP) on behalf of the Department. It is also responsible for the policy direction, administration and monitoring of the Newfoundland and Labrador Interchangeable Drug Products Formulary (the NIDPF) and the Tamper Resistant Prescription Drug Pad Program. The Division also provides Department representation on various Provincial, Atlantic and National pharmaceutical initiatives.

The Division has two locations; the head office located in St. John's and the assessment office located in Stephenville. As at March 31, 2014, there were 36 employees in the Division, 21 in St. John's and 15 in Stephenville.

The NLPDP provides financial assistance to eligible residents of the Province for the purchase of certain prescription drugs and drug benefits that are included on a benefits listing approved by the Department.

The mandate of the NLPDP is to provide coverage for prescription drugs and additional drug benefits approved by the Department as outlined in a Benefits List maintained by the NLPDP. Approved benefits provided by the NLPDP are supplied as part of five main plans: the Foundation Plan, the 65Plus Plan, the Access Plan, the Assurance Plan and the Select Needs Plan. A beneficiary may be eligible under more than one plan. The order of plan coverage is: Foundation, Assurance, 65Plus, and Access.

The NLPDP is the payer of last resort. This means the NLPDP will pay prescription costs and other related benefits for which a person is eligible only where those services are not reimbursable by a third party.

The NIDPF is a list of commonly used lower cost generic drugs that can be substituted for higher cost brand name drugs. The objective of the NIDPF and associated legislation is to assist all residents of the Province in obtaining prescription drugs of acceptable quality at reasonable prices. Products listed as interchangeable in the NIDPF have no relation to the NLPDP Benefits List.

The Audit Services Section, which is within the Audit Claims and Integrity Division of the Department, is responsible for performing audits of benefits paid under the NLPDP. The audits of the NLPDP are regulated by the *Pharmaceutical Services Act*.

Objectives

The objectives of our review were to determine whether:

1. individuals insured under the NLPDP met initial and continued eligibility criteria;

2. reimbursements of drugs dispensed to persons eligible under the NLPDP were accurate and appropriate;

3. there was established guidance to ensure that the audit process for claims under the NLPDP was complete and appropriate; and

4. the approval to add and remove drugs to and from the NIDPF was appropriate.

Scope

Our review covered the period April 1, 2012 to September 30, 2014. We reviewed the four larger plans administered by the NLPDP: the Foundation Plan, the 65Plus Plan, the Access Plan, and the Assurance Plan and the audit process for claims within these plans. Our review did not focus on the Selected Needs Plan, as the coverage was specific to a small number of beneficiaries and actual expenditures of this plan were relatively small. We tested a sample of claims across all four plans that we reviewed, focusing on the processes within the NLPDP. We did not extend our testing to cover the processes of the pharmacies that participate in the NLPDP. Our review also covered the administration of the NIDPF and included a sample of drug additions to the NIDPF. Sample selections for testing were non-statistical and random.

We completed our review in February 2015.

Conclusions

Objective 1

For the sample of prescriptions filled, individuals insured under the NLPDP that were chosen for review were determined to have met initial and continued eligibility criteria.

Objective 2

For the 20 Medigent system business rules reviewed and the sample of detailed claims tested against these business rules, we determined that the reimbursements of drugs dispensed to persons eligible under the NLPDP were accurate and appropriate in those instances. However, we found that there was one business rule that was not active during the period of our review and we saw evidence that there were claims reimbursed that were not in compliance with the NLPDP policy for which the inactive business rule was intended to ensure compliance.

Objective 3

While there were documents, such as the NLPDP Provider Guide (the Provider Guide) and NLPDP policy manual maintained by NLPDP, that provided details of programs under audit by the Audit Services Section, there was no internal guidance established by the Audit Services Section to guide the audit process for claims under the NLPDP to ensure the audit process was complete and appropriate.

Objective 4

In the sample of drugs reviewed, we found that the approval to add the drugs to the NIDPF was appropriate. There was no removal of drugs from the NIDPF during the period of our review.

Findings

Initial and Continued Eligibility

Initial Eligibility

1. Based on our review of the NLPDP Access and Assurance application form for initial eligibility, we determined that the form contained the required information to allow a determination of whether an applicant met the requirements of the NLPDP policy.

2. The sample of 70 initial eligibility applications we reviewed contained all information required by the NLPDP.

3. The sample of 10 applicants reviewed were accurately assessed against the relevant criteria of the NLPDP plans and were correctly accepted into the plan within which they had been placed.

Monitoring of Continued Eligibility

4. For the 55 claims sampled within the Foundation Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled.

5. For the 34 claims sampled within the 65Plus Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled.

6. For the six claims sampled within the Access Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled. The co-pay percentages for the claims reviewed were accurate.

7. For the five claims sampled within the Assurance Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled. The co-pay percentages for the claims reviewed were accurate.

Reimbursements of Dispensed Drugs

System Controls

8. The 20 Medigent system business rules tested were operating effectively to prevent the reimbursement of claims that did not comply with the Provider Guide.

9. The Medigent system refill business rule was not active during the period of our review. Evidence reviewed indicated that during the period of our review, there were claims that exceeded the maximum refills authorized. Therefore, claims had been reimbursed that were not in compliance with the Provider Guide.

10. The Medigent system did not adjudicate compound ingredients and did not prevent prescription splitting from occurring during the period of our review. Therefore, there was an inherent risk of unauthorized claims and professional fees charges for compound medications and prescription splitting that were beyond that allowed in the Provider Guide.

Payer of Last Resort

11. During the period covered by our review, the coordination of benefits rules for payer of last resort tested were operating effectively to ensure compliance with requirements outlined in the Provider Guide.

12. The 100 claims tested for coordination of benefits for payer of last resort complied with the Provider Guide.

Professional Fees

13. During the period covered by our review, the professional fee rules tested found compliance with thresholds outlined in the Provider Guide.

14. Professional fees charged in the 100 claims we tested complied with the Provider Guide.

Monitoring of System

15. We determined that during the period of our review, mechanisms were in place to monitor that the Medigent system was working effectively and that issues were addressed in a timely manner.

16. While there was testing of new business rules prior to implementation of the rule in the Medigent system during the period of our review, there was no formal monitoring process of the Medigent system business rules to ensure that the rules continue to operate effectively subsequent to the implementation.

Audit of Reimbursed Claims

Audit Policies and Procedures

17. During the period of our review, the Audit Services Section did not have written policies and procedures to guide the audits completed to ensure the audits were conducted in accordance with generally accepted auditing standards as required by legislation.

18. As at September 30, 2014, an audit section to be included in the Provider Guide had been in progress for approximately seven years and was in draft form and not yet available to Providers.

Audits of Claims

19. For the selection of audit files of the Audit Services Section that we reviewed, there was no documentary evidence of supervision and review of the files as required by generally accepted auditing standards, and the files did not have documentation of planning details that we expected to see.

20. For the selection of audit files of the Audit Services Section that we reviewed, there was no documentary evidence of the validation of audit findings with officials of the NLPDP prior to sending results letters to the Providers audited.

21. One audit that had been completed by the Audit Services Section during the scope of our review contained errors within the audit work that impacted calculated Provider recovery amounts. The errors were discovered by Bell Canada during a review of the recovery adjustments it had been instructed to make by the Audit Services Section. The Audit Services Section had not realized these errors had occurred in the audit work. These errors may have been prevented had the calculations been properly reviewed by senior Audit Services Section staff and validated by NLPDP officials prior to audit completion.

22. An annual report was not prepared by the Audit Services Section and submitted to the Minister for the fiscal year ended March 31, 2014, which is in contravention of the *Pharmaceutical Services Act.*

23. In comparison to the prescription drug expenditures of the NLPDP during the scope of our review, the number of audits started and completed was insignificant. As a result, the Department may be missing opportunities to ensure compliance with the NLPDP.

24. 58% of the audits that were outstanding as at September 30, 2014, had been in progress between three and eight years.

Resolution of Audit Findings

25. Findings of audits during the scope of our review were not being monitored to ensure the complete recovery of all claims errors.

26. During the period of our review, information was not being accumulated from audit results to determine whether there was widespread misinterpretations of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers. Analysis of such information may allow the Department to communicate with Providers to prevent future misinterpretations or incorrect billings.

Maintenance of the Newfoundland and Labrador Interchangeable Drug Products Formulary

Additions to the NIDPF

27. The drug submission checklist used by the Division during the period of our review included the drug addition requirements of the *Interchangeable Drug Products Formulary Regulations.*

28. The completed drug submission checklists we reviewed for 40 drug additions to the NIDPF contained all required information.

29. The level of review completed for the 40 additions to the NIDPF that we tested was appropriate.

Pricing of Drugs on the NIDPF

30. The pricing of drugs on the NIDPF during the period of our review was in accordance with the *Interchangeable Drug Products Formulary Regulations.*

Recommendations

1. The Department should determine whether the Medigent system refill business rule can be activated to prevent the reimbursement of claims that exceed the maximum refills authorized or determine some other course of action to prevent disallowed reimbursements from occurring.

2. The Department should determine whether modifications to the Medigent system can reduce the risk of unauthorized claims and payment of inappropriate professional fees from compound claims and prescription splitting.

3. The Department should develop a formal monitoring process of the Medigent system business rules to ensure that the rules continue to operate effectively subsequent to implementation.

4. The Department should develop policies and procedures to guide the audits performed by the Audit Services Section to ensure the audits are in compliance with legislation and the CPA Canada Handbook.

5. The Department should ensure that information is available to Providers regarding their role in the audit process.

6. The Department should ensure that requirements of the CPA Canada Handbook regarding audit planning, supervision, and review are met and there is documentation in the audit files to provide evidence that these requirements are met.

7. The Department should ensure that an annual report is prepared by the Audit Services Section for each fiscal year to ensure compliance with the *Pharmaceutical Services Act*.

8. The Department should ensure that the volume of audits of the NLPDP is sufficient and the audits are completed within a reasonable timeframe.

9. The Department should ensure that the status of audit findings are being tracked for monitoring purposes to ensure the complete recovery of amounts pertaining to claims errors.

10. The Department should accumulate information from audit results to determine whether there are widespread misinterpretations of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers.

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

1. individuals insured under the Newfoundland and Labrador Prescription Drug Program (the NLPDP) met initial and continued eligibility criteria;

2. reimbursements of drugs dispensed to persons eligible under the NLPDP were accurate and appropriate;

3. there was established guidance to ensure that the audit process for claims under the NLPDP was complete and appropriate; and

4. the approval to add and remove drugs to and from the Newfoundland and Labrador Interchangeable Drug Products Formulary (NIDPF) was appropriate.

Scope

Our review covered the period April 1, 2012 to September 30, 2014. We reviewed the four larger plans administered by the NLPDP: the Foundation Plan, the 65Plus Plan, the Access Plan, and the Assurance Plan and the audit process for claims within these plans. Our review did not focus on the Selected Needs Plan, as the coverage was specific to a small number of beneficiaries and actual expenditures of this plan were relatively small. We tested a sample of claims across all four plans that we reviewed, focusing on the processes within the NLPDP. We did not extend our testing to cover the processes of the pharmacies that participate in the NLPDP. Our review also covered the administration of the NIDPF and included a sample of drug additions to the NIDPF. Sample selections for testing were non-statistical and random.

We completed our review in February 2015.

Background

The Pharmaceutical Services Division (the Division) of the Department of Health and Community Services (the Department) is responsible for operating the NLPDP on behalf of the Department. It is also responsible for the policy direction, administration and monitoring of the Newfoundland and Labrador Interchangeable Drug Products Formulary (the NIDPF) and the Tamper Resistant Prescription Drug Pad Program. The Division also provides Department representation on various Provincial, Atlantic and National pharmaceutical initiatives.

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The NLPDP provides financial assistance to eligible residents of the Province for the purchase of certain prescription drugs and drug benefits that are included on a benefits listing approved by the Department.

The mandate of the NLPDP is to provide coverage for prescription drugs and additional drug benefits approved by the Department as outlined in a Benefits List maintained by the NLPDP. Approved benefits provided by the NLPDP are supplied as part of five main plans: the Foundation Plan, the 65Plus Plan, the Access Plan, the Assurance Plan and the Select Needs Plan. A beneficiary may be eligible under more than one plan. The order of plan coverage is: Foundation, Assurance, 65Plus, and Access.

The NLPDP is the payer of last resort. This means the NLPDP will pay prescription costs and other related benefits for which a person is eligible only where those services are not reimbursable by a third party.

The NIDPF is a list of commonly used lower cost generic drugs that can be substituted for higher cost brand name drugs. The objective of the NIDPF and associated legislation is to assist all residents of the Province in obtaining prescription drugs of acceptable quality at reasonable prices. Products listed as interchangeable in the NIDPF have no relation to the NLPDP Benefits List.

The Audit Services Section, which is within the Audit Claims and Integrity Division of the Department, is responsible for performing audits of benefits paid under the NLPDP. The audits of the NLPDP are regulated by the *Pharmaceutical Services Act*.

Table 1 provides the Departmental expenditures for each of the five plans, as well as the number of claims paid under each plan for the years ended March 31, 2013 and 2014.

Table 1

Department of Health and Community Services
NLPDP Plan Expenditures and Claims
For the years ended March 31

Plan	2013			2014		
	Expenditure	Number of Claims	Average Expenditure per Claim	Expenditure	Number of Claims	Average Expenditure per Claim
Foundation	$66,437,770	1,825,496	$36.39	$62,094,278	1,880,386	$33.02
65Plus	51,239,225	1,258,007	40.73	46,673,951	1,277,932	36.52
Access	9,023,293	399,717	22.57	8,133,057	378,381	21.49
Assurance	18,988,586	305,800	62.09	19,208,706	292,564	65.66
Selected Needs	627,994	2,296	273.52	809,184	2,123	381.15
Total	**$146,316,868**	**3,791,316**	**$38.59**	**$136,919,176**	**3,831,386**	**$35.74**

Source: Department of Health and Community Services

As shown in Table 1, the largest expenditures and number of claims are within the Foundation Plan and 65Plus Plan. The Foundation Plan had expenditures of $62.1 million and 1.9 million claims during the year ended March 31, 2014. The 65Plus Plan had expenditure of $46.7 million and 1.3 million claims during the year ended March 31, 2014. The average expenditure per claim across all plans was $35.74 per claim for the year ended March 31, 2014.

Detailed Observations

1. Initial and Continued Eligibility

Objective

To determine whether individuals insured under the NLPDP met initial and continued eligibility criteria.

Conclusion

For the sample of prescriptions filled, individuals insured under the NLPDP that were chosen for review were determined to have met initial and continued eligibility criteria.

Overview

Eligibility details for each of the NLPDP plans are as follows:

- **The Foundation Plan** - provides 100% coverage of eligible prescription drugs to individuals and families in receipt of income support benefits through the Department of Advanced Education and Skills (AES). It also provides coverage to certain individuals receiving services through the Regional Health Authorities (RHAs), including children in the care of the Department of Child, Youth and Family Services and individuals in supervised care.

- **The 65Plus Plan** - provides coverage of eligible prescription drugs to residents 65 years of age and older who receive both Old Age Security Benefits (OAS) and the Guaranteed Income Supplement (GIS). Beneficiaries are responsible for payment of the dispensing fee up to a maximum of $6.

- **The Access Plan** - provides individuals and families with low income access to eligible prescription drugs. The amount of coverage is determined by net income levels and family status. The program is available to:

  - families with children, including single parents, with net annual incomes of $42,870 or less;

  - couples without children with net annual income of $30,009 or less; and

  - single individuals with net income of $27,151 or less.

- **The Assurance Plan** - offers protection for individuals and families against the financial burden of eligible high drug costs, whether it be from the cost of one extremely high drug or the combined cost of different drugs. Depending on their income level, the annual out-of-pocket eligible drug costs of individuals and families is capped at either 5, 7.5 or 10 percent of their net family income:

  - those with net income up to $39,999 pay a maximum of 5% of their net income for eligible drugs;

  - those with net income of $40,000 up to $74,999 pay a maximum of 7.5% of their net income for eligible drugs; and

  - those with net income of $75,000 up to $149,999 pay a maximum of 10% of their net income for eligible drugs.

Table 2 shows the number of beneficiaries under each plan.

Table 2

Department of Health and Community Services
Number of Beneficiaries under Each Plan
For the years ended March 31

Plan	2013	2014
Foundation	57,257	56,550
65Plus	44,272	43,943
Access	30,014	27,691
Assurance	8,706	8,025
Total	**140,249**	**136,209**

Source: Department of Health and Community Services

We reviewed the initial and continued eligibility for beneficiaries under each of the four major NLPDP plans. We identified findings in the following areas:

A. Initial Eligibility
B. Monitoring of Continued Eligibility

1A. Initial Eligibility

Introduction

Initial eligibility processes for each of the NLPDP plans varies by plan.

The Access and Assurance plans require individuals to submit a completed application form for review. Both plan applications require such details as: income, family status and the number of dependants. The Assurance Plan requires the applicant's drug history to be submitted. An applicant to the Assurance Plan is assessed for eligibility within both plans. If an applicant to the Access Plan chooses to submit their drug history, the individual is assessed against both plans and is placed in the plan that provides the best coverage. Application details are entered into the NLPDP database. The applicant's details are then sent to the Canada Revenue Agency (CRA) to be validated against the applicant's current year income tax information. Applications that pass validation with the CRA are then assessed to determine eligibility for the applicable plan and the appropriate co-pay percentage.

Eligibility within the Foundation or 65Plus Plans is based on information received from external sources. Eligibility within the Foundation Plan is determined through a listing of eligible beneficiaries received from AES and the RHAs. Eligibility within the 65Plus Plan is determined through a listing from Service Canada of individuals who are receiving OAS and GIS.

There were 25,694 beneficiaries added to the Access and Assurance Plans within the period of our review. We reviewed a sample of 70 applications that had been processed and had resulted in benefits granted during the period of our review. Eligibility of individuals under the Foundation and 65Plus Plans for both initial and continued eligibility is based on periodic listings received by the NLPDP. The review of these processes are included within the review details in Section 1B – Monitoring of Continued Eligibility.

Our review indicated the following:

Application Form Completeness

NLPDP policy requires that individuals meet specific criteria to be eligible to receive benefits under the Access or Assurance Plans. To ensure applicants meet these criteria, the NLPDP validates application information against CRA income tax information. We expected that the application would require information about the applicant, their spouse, and dependents such as their name, birth date, MCP number and social insurance number. We also expected that the application would contain a consent form to allow the NLPDP to validate an individual's information with the CRA.

Our review determined that the applications contained the required information to allow the NLPDP to ensure that individuals met the specific plan criteria.

Finding

1. Based on our review of the NLPDP Access and Assurance application form for initial eligibility, we determined that the form contained the required information to allow a determination of whether an applicant met the requirements of the NLPDP policy.

Application Completeness

Our review of the 70 applications sampled for the Access and Assurance Plans indicated that the applications contained all required information.

Finding

2. The sample of 70 initial eligibility applications we reviewed contained all information required by the NLPDP.

Eligibility Accuracy

We reviewed the details within 10 of the 70 applications sampled for the Access and Assurance Plans. We determined that the successful applicant has been accurately assessed against the relevant criteria of the plans and had been correctly accepted into the plan within which they had been placed.

Finding

3. The sample of 10 applicants reviewed were accurately assessed against the relevant criteria of the NLPDP plans and were correctly accepted into the plan within which they had been placed.

1B. Monitoring of Continued Eligibility

Introduction

Beneficiaries of each of the NLPDP plans are not required to provide updated information to continue receiving benefits. The NLPDP system reassesses a beneficiary's eligibility within a particular plan based on updated information interfaced into the system from numerous sources.

Reassessments of individuals in the Foundation Plan are completed monthly based on information received from AES. For beneficiaries in the Foundation Plan, where services are provided through a RHA, changes to eligibility status are provided by the RHAs to the NLPDP as they occur. Reassessments of individuals in the 65Plus Plan are completed monthly based on information received from Service Canada.

Under the Access and Assurance plans, reassessments are completed against CRA information. Reassessments are completed annually for the Access Plan and every six months for the Assurance Plan. When a reassessment is completed for one of these plans, the beneficiaries are evaluated against both plans and the plan that provides the best coverage is chosen.

Within the scope period of our review, there were approximately 11 million claims processed within these four plans. The data population used in our testing included all transactions through the system, including both claims paid and reversed. During our review, we examined a sample of 100 claims to ensure that, at the date the beneficiary filled their prescription, they were eligible to receive benefits under their respective plan.

Our review indicated the following:

Foundation Plan

Eligibility under the Foundation Plan is reassessed monthly. Individuals and families who receive Income Support are eligible to receive coverage under the Foundation Plan. The NLPDP receives a monthly listing of Income Support recipients from AES. The process of validating continued eligibility is completed through an interface of the information received from AES.

Of the 100 claims chosen in our random sample, 55 related to the Foundation Plan. To ensure that the beneficiaries sampled were eligible to receive benefits at the date their prescriptions were filled, we requested confirmation from AES. AES confirmed that 31 of the beneficiaries were on Income Support at the date the prescription was filled. The remaining 24 beneficiaries were confirmed to have been receiving services through a RHA at the date of the prescription fill.

We determined that the 55 beneficiaries sampled were eligible to receive benefits under the Foundation Plan at the date that the prescription sampled was filled.

Finding

4. For the 55 claims sampled within the Foundation Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled.

65Plus Plan

Eligibility under the 65Plus Plan is reassessed annually. In August of each year, the NLPDP receive a current list of GIS recipients from Service Canada. The NLPDP also receive monthly updates from Service Canada of GIS recipient additions. The NLPDP system update is performed automatically as information from Service Canada is obtained.

Of the 100 claims chosen in our random sample, there were 34 claims relating to the 65Plus Plan. Service Canada requires that the NLPDP destroy any information received from them within two months of receipt. Therefore, we chose a sample of 34 claims for the 65Plus Plan outside of our scope period of review. The scope period of our review of continued eligibility for the 65Plus Plan was from October 2014 to January 2015.

To ensure that the beneficiaries sampled were eligible to receive benefits at the date their prescriptions were filled, we inspected the listing provided by Service Canada to confirm that the beneficiaries sampled were on the list and eligible to receive benefits.

We determined that the 34 beneficiaries sampled were eligible to receive benefits under the 65Plus Plan at the date that the prescription was filled.

Finding

5. For the 34 claims sampled within the 65Plus Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled.

Access Plan

Eligibility under the Access Plan is reassessed annually. During May and June of each year, the NLPDP system automatically begins a validation process against CRA information interfaced into the system. Beneficiary information within the Access Plan is validated against the CRA income tax information to ensure that a beneficiary's profile in the system contains accurate and up-to-date information. Following the CRA validation, beneficiaries are evaluated against the plan requirements by the system to confirm they are still eligible to receive benefits. Beneficiaries who continue to meet the plan requirements then have a new co-pay evaluation performed to determine their new co-pay percentage. In addition to reassessment under the Access Plan, the system uses the beneficiary's drug history to determine if they are eligible under the Assurance Plan. The beneficiary is placed in the plan that provides the best coverage.

Of the 100 claims chosen in our random sample, six claims related to the Access Plan. We reviewed system reassessment files that detailed the validation of each beneficiary's profile against the CRA income tax information. We also reviewed each individual's reassessment information to ensure that the beneficiary met the plan requirements. Our review indicated that the Access Plan beneficiaries sampled met the plan requirements during the period of the reviewed claims.

During our review, we recalculated the co-pay percentage for the claims reviewed. We determined that for the beneficiaries sampled, the co-pay percentages were accurate.

Finding

6. For the six claims sampled within the Access Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled. The co-pay percentages for the claims reviewed were accurate.

Assurance Plan

Eligibility under the Assurance Plan is reassessed every six months in April and October. The Assurance Plan follows the same reassessment procedure as the Access Plan. The system uses the beneficiary's drug history under the Assurance Plan to determine if they are still eligible to receive benefits. In October, the NLPDP system automatically begins a validation process against CRA information interfaced into the system. Due to the timing of income tax filing, the April reassessment does not include a CRA validation because it would use the same income tax information as the October validation. Beneficiaries who pass the CRA validation are then evaluated against the plan requirements by the system to confirm they are still eligible to receive benefits. Beneficiaries who continue to meet the plan requirements then have a new co-pay evaluation performed to determine their new co-pay percentage.

Of the 100 claims chosen in our random sample, there were five claims relating to the Assurance Plan. We reviewed system reassessment files that detailed the validation of each beneficiary's profile against the CRA income tax information. We also reviewed each individual's reassessment information to ensure that the beneficiary met the plan requirements. Our review indicated that the Access Plan beneficiaries sampled continued to meet the plan requirements.

During our review, we recalculated the co-pay percentage for the claims reviewed. We determine that for the beneficiaries sampled, the co-pay percentages were accurate.

Finding

7. For the five claims sampled within the Assurance Plan, the beneficiaries met the continued eligibility criteria at the date the prescription was filled. The co-pay percentages for the claims reviewed were accurate.

2. Reimbursements of Dispensed Drugs

Objective

To determine whether reimbursements of drugs dispensed to persons eligible under the NLPDP were accurate and appropriate.

Conclusion

For the 20 Medigent system business rules reviewed and the sample of detailed claims tested against these business rules, we determined that the reimbursements of drugs dispensed to persons eligible under the NLPDP were accurate and appropriate in those instances. However, we found that there was one business rule that was not active during the period of our review and we saw evidence that there were claims reimbursed that were not in compliance with the NLPDP policy for which the inactive business rule was intended to ensure compliance.

Overview

In 2006, the NLPDP contracted with Bell Canada to design and administer the Medigent system. This system allows those pharmacies eligible to provide drugs under the NLPDP programs (Providers) to enter beneficiary claims for reimbursement in real time. The Medigent system was completed and put into use in March 2007.

To allow the Medigent system to function in real time, the NLPDP created system controls, or business rules, that govern the claim reimbursement process. The Medigent system is designed to reject claims that are submitted with missing or incorrect information. The business rules evaluate the information submitted by a Provider to determine whether the claim is accurate and complies with NLPDP requirements and to ensure the beneficiary is eligible to receive benefits under one of the NLPDP plans.

Claims that are accepted by the Medigent system are submitted to Bell Canada for reimbursement. Bell Canada issues a payment to the Providers on behalf of the NLPDP. Bell Canada is reimbursed by the NLPDP for the amount of claims paid on a bi-weekly basis.

In addition to claims submitted through the Providers, there are also claims that are required to be submitted directly to Bell Canada for manual entry. These claims include, for example, beneficiaries that have a private insurance company that does not reimburse Providers at the time of the transactions. Because the NLPDP is the payer of last resort, the beneficiaries are required to submit their insurance claim first, then after their insurance company has reimbursed the claim, the beneficiary may submit the claim to Bell Canada for remaining eligible reimbursement. These claims are entered into the Medigent system by Bell Canada and are evaluated against the same rules as claims submitted directly by the Provider.

There are 85 business rules that govern the Medigent system. Our review focused primarily on system controls testing of the 20 rules that affect the dollar amount of the reimbursement Providers receive. We also reviewed claims transactions, on a sample basis, to ensure that they were in compliance with certain of the NLPDP requirements. We identified findings in the following areas:

A. System Controls
B. Payer of Last Resort
C. Professional Fees
D. Monitoring of System

2A. System Controls

Introduction

The Medigent system was developed to allow Providers the ability to submit claims for prescription reimbursement at the time the prescription is filled. To confirm the accuracy and completeness of the claims being submitted by the Providers, the NLPDP created business rules that would adjudicate the claims in real time and provide immediate feedback to the Providers.

The business rules within the Medigent system were created based on guidance and requirements within the NLPDP Provider Guide (the Provider Guide), which is created from the *Interchangeable Drug Products Formulary Regulations* and the Pharmacies Association of Newfoundland and Labrador (PANL) agreement.

Our review indicated the following:

Business Rules Effectiveness

During our review, we performed control testing on 20 of the business rules. Our primary focus for the control testing were the business rules that affect the amount of reimbursement Providers receive. Examples of these rules include:

- the lowest cost drug in a category was charged back to the NLPDP;
- the Providers professional fees did not exceed the fees outlined in the PANL agreement;
- customers were not provided benefits for a NLPDP program they were not eligible for; and
- a prescription was not entered more than once.

In addition to ensuring information entered by the Provider is in compliance with policy and legislation, the business rules also prevent incomplete claims from being entered.

When the business rules determine that there is an issue with a claim, the Medigent system rejects the claim and provides a message explaining why the claim could not be processed. The Provider must then fix the claim and resubmit it for adjudication. The Medigent system keeps a log of every claim entered for a beneficiary which is available to the NLPDP for review.

We determined that the 20 business rules tested were operating effectively to prevent incorrect or incomplete claims from being processed.

Finding

8. The 20 Medigent system business rules tested were operating effectively to prevent the reimbursement of claims that did not comply with the Provider Guide.

Refills Authorized

Section 10.20 of the Provider Guide states that "*the Program does not provide coverage for refills or quantities in excess of that authorized by the prescriber*". The Medigent system has a business rule designed to prevent claims from being reimbursed if the maximum number of refills authorized is exceeded.

During our review, we identified that the "Refill Authorized" business rule was not active during the period of our review. Department officials advised that when activated, the business rule had caused system processing delays during claims adjudication. Under the Service Agreement between the NLPDP and Bell Canada, claims are required to be adjudicated and processed within four seconds of being submitted. The delays caused claims adjudication processing times to exceed the requirements of the Bell Canada Service Agreement.

The NLPDP claims audits performed by the Audit Services Section during the period of our review, indicated that within their samples of claims reviewed and compared to prescriptions, they identified claims reimbursements in which the refills reimbursed exceeded the maximum refills authorized. Therefore, claims had been reimbursed that were not in compliance with the Provider Guide.

Finding

9. The Medigent system refill business rule was not active during the period of our review. Evidence reviewed indicated that during the period of our review, there were claims that exceeded the maximum refills authorized. Therefore, claims had been reimbursed that were not in compliance with the Provider Guide.

Compounding and Prescription Splitting

There are certain situations that require more professional judgment by the Provider when filling prescriptions for beneficiaries. Compounding and prescription splitting are two such situations.

Compounding is the creation of a medication by a Provider from multiple ingredients because the medication is not available from a manufacturer in the desired strength or containing the ingredients prescribed by the physician. Compounds are claimed in the Medigent system within a single claim code through the keying of one total cost for all ingredients. Therefore, each ingredient used to create the medication is not accounted for separately. The Medigent system does not adjudicate the compound ingredients claimed under this code because there are no designated criteria against which to evaluate the claims. Providers receive a professional fee based on the total cost of the medication. Therefore, our review indicated that there was an inherent risk of unauthorized claims and professional fee charges related to the prescribing of compounds that were beyond that allowed in the Provider Guide.

Prescription splitting is when the Provider separates a prescription into two or more fills. Prescription splitting can be useful when a beneficiary is starting a new drug or to prevent abuse of a certain drug. Prescription splitting can be utilized by a Provider based on their professional judgment. Providers receive a professional fee each time a prescription is filled. The Medigent system does not prevent prescription splitting from occurring, as it must allow for professional judgment. Therefore, our review indicated that there was an inherent risk of unauthorized prescription splitting and professional fee charges that were beyond that allowed in the Provider Guide.

Finding

10. The Medigent system did not adjudicate compound ingredients and did not prevent prescription splitting from occurring during the period of our review. Therefore, there was an inherent risk of unauthorized claims and professional fee charges for compound medications and prescription splitting that were beyond that allowed in the Provider Guide.

2B. Payer of Last Resort

Introduction

The Provider Guide requires that the NLPDP is the payer of last resort, meaning that beneficiaries that also have private drug plan coverage are required to submit a claim to their coverage provider prior to receiving benefits under their NLPDP plan. The Medigent system recognizes this as coordination of benefits.

The Medigent system has a business rule that prevents claims from being reimbursed for beneficiaries with third party coverage before the coverage provider has reimbursed their portion of the cost first.

Our review indicated the following:

Coordination of Benefits

During our review we performed control testing on the coordination of benefits rules in the Medigent system. We determined that the business rules were operating effectively to prevent claims from being reimbursed before the third party coverage provider claim had been submitted.

In addition to the business rule testing, we sampled 100 claims that were paid during our scope period. We determined that for the 100 samples tested, there were no instances where claims were paid without the private drug coverage being paid first.

Findings

11. During the period covered by our review, the coordination of benefits rules for payer of last resort tested were operating effectively to ensure compliance with requirements outlined in the Provider Guide.

12. The 100 claims tested for coordination of benefits for payer of last resort complied with the Provider Guide.

2C. Professional Fees

Introduction

Providers are able to claim a professional fee for filling prescriptions to customers receiving benefits from one of the NLPDP plans. The professional fee rates are outlined in the Provider Guide. The professional fees are based on the cost of the drug dispensed.

The Medigent system has business rules to prevent professional fees from being paid that do not comply with the Provider Guide from being paid.

Our review indicated the following:

Professional Fees

During our review we performed control testing on the professional fee rules in the Medigent system. We determined that the business rules were operating effectively to ensure professional fees paid were within the thresholds outlined in the Provider Guide.

In addition to the business rule testing, we sampled 100 claims that were paid during our scope period. We determine that for the 100 samples tested, there were no instances where professional fees were paid above the amounts outlined in the Provider Guide.

Findings

13. During the period covered by our review, the professional fee rules tested found compliance with thresholds outlined in the Provider Guide.

14. Professional fees charged in the 100 claims we tested complied with the Provider Guide.

2D. Monitoring of System

Introduction

In order for the NLPDP to be effectively administered, the Medigent system must operate with minimal downtime. We would expect processes in place to ensure that the system is working effectively and procedures to address concerns in a timely manner. The business rules of the system must also operate effectively at all times to ensure that unauthorized claims are not processed.

Our review indicated the following:

System Monitoring

There are mechanisms in place to monitor real time adjudication. Providers that experience issues with the Medigent system can contact the NLPDP both during regular business hours and after hours so that issues can be addressed. There are also automated processes in place to monitor the activity on the system and alert the NLPDP Application Management Team if there is a potential concern that must be investigated. We reviewed documentation maintained by the NLPDP Application Management Team regarding system issues that occurred during the period of our review and determined that the processes addressed concerns in a timely manner.

The effective operating of the Medigent system business rules is ensured through NLPDP's requirement that validation and testing of each new business rule is to occur in a test environment prior to the implementation of the rule in the live Medigent system. We reviewed documentation maintained by NLPDP that was last updated in July 2014 and determined that test scenarios had been completed to cover past business rules prior to implementation. However, we determined that, once implemented, there is no formal monitoring process for the business rules to ensure that they continue to operate effectively at all times.

Findings

15. We determined that, during the period of our review, mechanisms were in place to monitor that the Medigent system was working effectively and that issues were addressed in a timely manner.

16. While there was testing of new business rules prior to implementation of the rule in the Medigent system during the period of our review, there was no formal monitoring process of the Medigent system business rules to ensure that the rules continue to operate effectively subsequent to the implementation.

3. Audit of Reimbursed Claims

Objective

To determine whether there was established guidance to ensure that the audit process for claims under the NLPDP was complete and appropriate.

Conclusion

While there were documents, such as the Provider Guide and NLPDP policy manual maintained by NLPDP, that provided details of programs under audit by the Audit Services Section, there was no internal guidance established by the Audit Services Section to guide the audit process for claims under the NLPDP to ensure the audit process was complete and appropriate.

Overview

Section 29 of the *Pharmaceutical Services Act* states that: "*In order to determine compliance with the Newfoundland and Labrador Prescription Drug Program, an audit may be performed under this Part to determine compliance with this Act, the regulations, policies and the terms and conditions of participation in the program*."

The Audit Services Section is part of the Audit and Claims Integrity Division which reports to the Assistant Deputy Minister of Corporate Services at the Department. The Audit Services Section is responsible for the audit of the NLPDP.

The Audit Services Section has four employees who conduct audits of claims within the NLPDP:

- Manager of Medical Audit and Compliance;
- Senior Departmental Audit Officer; and
- two staff auditors.

Section 30 of the *Pharmaceutical Services Act* requires that: "*Audits performed under this Act shall be performed according to generally accepted auditing standards* (GAAS) *and audits may be performed using those techniques which may be prescribed by regulation that are considered necessary to complete audits according to the required standard*."

We reviewed the audit processes of the Audit Services Section pertaining to the NLPDP and the associated audit files. We identified findings in the following areas:

A. Audit Policies and Procedures
B. Audits of Claims
C. Resolution of Audit Findings

3A. Audit Policies and Procedures

Introduction

A policy is a guiding principle used to set direction in an organization. A procedure is a series of steps to be followed as a consistent and repetitive approach to accomplish an end result. Policies and procedures are a useful training tool for new employees and a good reference tool for existing staff. We expected to see policies and procedures in place to guide the Audit Services Section's processes around the audit of the NLPDP to determine compliance with legislation governing the NLPDP and the policies and procedures of the NLPDP.

The *Pharmaceutical Services Act* requires audits performed on the NLPDP to follow generally accepted auditing standards. These standards are currently defined in the CPA Canada Handbook - Assurance (the Handbook).

Handbook Section 5030 *Quality Control Procedures for Assurance Engagements Other Than Audits of Financial Statements and Other Historical Financial Information* contains guidance applicable to the auditing standards that are to be met in an audit such as that required of the NLPDP in Section 30 of the *Pharmaceutical Services Act.*

Our review indicated the following:

Policies and Procedures

To ensure compliance with the Handbook, guidance outlined in Handbook Section 5030 must be followed when performing the audit of the NLPDP. Handbook Section 5030.26 includes guidance on planning, supervision and review, which are of particular significance to the audit of the NLPDP:

> "*The practitioner should take responsibility for the performance of the assurance engagement in compliance with professional standards and regulatory and legal requirements, and for the issuance of a practitioner's report that is appropriate in the circumstances. In particular, the practitioner should ensure that assurance engagement work is adequately planned, properly supervised and appropriately reviewed.*"

The Audit Services Section did not have written policies to guide audits completed by the Audit Services Section to ensure the Handbook standards were being met. The Audit Services Section also did not have documented procedures to outline a detailed methodology and audit file documentation requirements for staff when completing an audit.

Finding

17. During the period of our review, the Audit Services Section did not have written policies and procedures to guide the audits completed to ensure the audits were conducted in accordance with generally accepted auditing standards as required by legislation.

Draft Audit Section of the Provider Guide

Guidance to Providers regarding policies and requirements of the NLPDP is outlined in the Provider Guide. This document is given to Providers when they begin participation in the NLPDP. The current version, as at September 30, 2014, of the Provider Guide does not have detailed information for the Provider that would allow the Provider to understand the audit requirements and processes. The audit section of the document currently indicates that the section is not yet available. The Provider Guide has been in use and available to Providers since 2007, which means that the audit section of the Provider Guide has been in progress for approximately seven years. We were provided a draft of the section. The NLPDP and the Audit Services Section staff are not certain as to when the section will be issued and available for use within the Provider Guide.

Finding

18. As at September 30, 2014, an audit section to be included in the Provider Guide had been in progress for approximately seven years and was in draft form and not yet available to Providers.

3B. Audits of Claims

Introduction

The purpose of auditing claims of the NLPDP is to verify that prescriptions are being filled and claimed for reimbursement in accordance with legislation and policy.

Our review indicated the following:

Audit Documentation

The Audit Services Section does not have written policies and procedures to guide the completion of audits. We therefore reviewed their audit file documentation and assessed it against the CPA Handbook (Handbook), legislation and NLPDP policy. We expected to see evidence of planning, supervision and review as required by the Handbook. We also expected to see documentation that outlined the procedures performed and outcomes of those procedures.

We expected to see documentation of audit planning details that were determined prior to the commencement of an audit. This would include details such as: audit team planning meeting documentation; risk considerations that were reviewed; scope and expected timeframe of the audit; and background details, including previous audit results, on the auditee(s). Our review of audit working papers for the audits completed during the scope of our review indicated that documentation within the audit files did not provide the level of detail that we expected to see.

We expected to see evidence of supervision and review through sign-off of audit file documents by senior officials of the Audit Services Section. Our review of audit working papers for the audits completed during the scope of our review indicated that there was no evidence of supervision and review through sign-offs of the documents.

We also expected to see evidence that the Audit Services Section had validated audit findings with officials of the NLPDP prior to sending results letters to the Providers audited. Our review indicated that there was no evidence of validation of audit findings with officials of the NLPDP prior to sending results letters to the Providers audited.

We also expected to see documentation that outlined the procedures performed and outcomes of those procedures. Our review of audit working papers for the audits completed during the scope of our review indicated that there were documents that detailed the audit testing that was completed and issues that were noted during the testing.

Through our review of audit work and documentation on one audit that had been recently completed by the Audit Services Section, we became aware of errors that were made within the audit procedures performed. The auditor had performed incorrect calculations when evaluating claims that were reviewed during the audit. These errors resulted in incorrectly calculated recovery amounts communicated to Bell Canada for processing. Upon communication to Bell Canada advising recovery amounts for processing, Bell Canada staff determined that the recovery amounts were incorrect. These errors may have been prevented had the calculations been properly reviewed by senior Audit Services Section staff and validated by NLPDP officials prior to audit completion.

Findings

19. For the selection of audit files of the Audit Services Section that we reviewed, there was no documentary evidence of supervision and review of the files as required by generally accepted auditing standards, and the files did not have documentation of planning details that we expected to see.

20. For the selection of audit files of the Audit Services Section that we reviewed, there was no documentary evidence of the validation of audit findings with officials of the NLPDP prior to sending results letters to the Providers audited.

21. One audit that had been completed by the Audit Services Section during the scope of our review contained errors within the audit work that impacted calculated Provider recovery amounts. The errors were discovered by Bell Canada during a review of the recovery adjustments it had been instructed to make by the Audit Services Section. The Audit Services Section had not realized these errors had occurred in the audit work. These errors may have been prevented had the calculations been properly reviewed by senior Audit Services Section staff and validated by NLPDP officials prior to audit completion.

Audit Results Reporting

Section 35 of the *Pharmaceutical Services Act* states that: "*An annual report of audits performed under this Act, including decisions made and the outcomes of the audits, shall be prepared by auditors appointed under this Act and submitted to the minister*."

Section 5815 of the Handbook *Special Reports - Audit Reports on Compliance with Agreements, Statutes and Regulations* contains guidance applicable to the annual reporting of audit results of the NLPDP as required in Section 35 of the *Pharmaceutical Services Act.*

Audit Services Section officials advised that an annual report was not prepared and submitted to the Minister for the fiscal year ended March 31, 2014. An annual report had been prepared and submitted for the fiscal year ended March 31, 2013.

Finding

22. An annual report was not prepared by the Audit Services Section and submitted to the Minister for the fiscal year ended March 31, 2014, which is in contravention of the *Pharmaceutical Services Act*.

Claims Audits Activity

Claims audits performed by the Audit Services Section are categorized as follows:

- complaint or voluntary information – information received regarding the billing or pattern of a Provider from a number of sources;
- targeted items - may occur when claims appear to be subject to widespread misinterpretation or incorrect billing;
- random selection - claims are randomly selected across all Providers; and
- comprehensive - there is a focused review of one particular Provider, with a number of claims from that Provider reviewed.

During our review, we obtained a listing of claims audit activity that had occurred during the period April 1, 2012 to September 30, 2014. Table 3 shows the audit activity, per basis type, during the period.

Table 3

Department of Health and Community Services
NLPDP Audits Performed by the Audit Services Section

Audits during the period April 1, 2012 to September 30, 2014	Audit Basis				
	Complaint	**Targeted**	**Random**	**Comprehensive**	**Total**
In Progress - Start of Period	0	0	0	14	14
Started During Period	2	9	1	0	12
Completed During Period	(1)	(1)	0	0	(2)
In Progress - End of Period	**1**	**8**	**1**	**14**	**24**

Source: Department of Health and Community Services

All 14 of the comprehensive audits that had begun prior to the scope of our audit remained outstanding throughout our two and half year scope period. As at September 30, 2014, these audits had been in progress in the range of three to eight years. Status letters were sent out to each of the Providers in April of 2014 advising the Providers that the audits had not yet been concluded. Recovery amount estimates for the audits ranged between $1,588 and $18,019.

Of the 12 audits started during the two and half year period of our review, only 2 had been completed as at September 30, 2014. Given the magnitude of prescription drug payments ($136.9 million for 2013-14) through the NLPDP, we would have expected to see more work undertaken by the Audit Services Section.

Findings

23. In comparison to the prescription drug expenditures of the NLPDP during the scope of our review, the number of audits started and completed was insignificant. As a result, the Department may be missing opportunities to ensure compliance with the NLPDP.

24. 58% of the audits that were outstanding as at September 30, 2014, had been in progress between three and eight years.

3C. Resolution of Audit Findings

Introduction

Upon completion of an audit, the Audit Services Section advises the audited Providers of any required claim recovery amounts that have resulted from the audit. This notification is made through a letter that notes the total recovery amount and provides further details in an attachment to the letter.

Providers are given a period of time to appeal the recovery adjustment. Once that period is over, the Audit Services Section provides the claim recovery details to Bell Canada, who administers the Medigent System, and requests that Bell Canada put a recovery adjustment through against a future claim of the Provider.

Our review indicated the following:

Audit Findings Monitoring

To ensure the complete recovery of all amounts pertaining to claims errors found during the audits completed by the Audit Services Section, we would expect to see documentation for each audit that outlines such details as:

- Providers audited;
- prescription claims audited for each Provider, and;
- the status of:
  - results letter to each Provider,
  - appeals request from Provider,
  - recovery letter to Bell Canada, and
  - the processing of recovery amounts.

An audit can result in a number of different types of findings, ranging from unauthorized refill to drug cost overbilling. Audits can also consist of sampling of the approximately 200 Providers during the period of our review. We would expect to see results of audit findings compiled and monitored for final resolution.

We would also expect to see audit results accumulated to provide information about widespread misinterpretation of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers.

Our review indicated that there was no detail listing maintained that outlined the detailed status and monitoring that we would have expected to see. We also determined that there were no analysis reports available for use.

Findings

25. Findings of audits during the scope of our review were not being monitored to ensure the complete recovery of all claims errors.

26. During the period of our review, information was not being accumulated from audit results to determine whether there was widespread misinterpretations of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers. Analysis of such information may allow the Department to communicate with Providers to prevent future misinterpretations or incorrect billings.

4. Maintenance of the Newfoundland and Labrador Interchangeable Drug Products Formulary

Objective

To determine whether the approval to add and remove drugs to and from the NIDPF was appropriate.

Conclusion

In the sample of drugs reviewed, we found that the approval to add the drugs to the NIDPF was appropriate. There was no removal of drugs from the NIDPF during the period of our review.

Overview

The NIDPF is a list of generic drugs grouped within categories of therapeutic equivalence to a brand name drug. The purpose of the NIDPF is to provide a listing of lower cost options that may be used as a substitute for higher cost brand name options. The objective of the NIDPF and associated legislation is to assist all residents of the Province in obtaining prescription drugs of acceptable quality at reasonable prices. Products listed as interchangeable in the NIDPF have no relation to the NLPDP Benefits List.

When a Provider receives a prescription for a drug listed on the NIDPF, the Provider is required to dispense the lowest cost option of the drug in the NIDPF category. Customers are able to request the dispensing of a higher cost option, however, the Provider must notify the customer of the price difference between the drug dispensed and the lowest cost option. Beneficiaries of the NLPDP must pay the difference in cost if they choose a higher cost option.

Companies that wish to get their drugs added to the NIDPF are required to forward their submissions electronically to the Division. Submissions are reviewed to confirm they meet the requirements set out in the *Interchangeable Drug Products Formulary Regulations* (the *Regulations*).

There are also situations in which drugs will be removed from the NIDPF. Removals from the NIDPF are less common than additions. Drugs are generally removed because: the manufacturer discontinues a drug, there is a price dispute between the Division and the manufacturer, or the manufacturer requests a drug be taken off the NIDPF.

The NIDPF is officially published on April 1 and October 1 of each year. In addition to the official publications, there are supplements published on the first of each month. These supplements include any drug submissions that have been approved during the month.

We reviewed the additions to the NIDPF and the pricing of drugs on the NIDPF. There were no drug removals during the period of our review. We identified findings in the following areas:

A. Additions to the NIDPF
B. Pricing of Drugs on the NIDPF

4A. Additions to the NIDPF

Introduction

Submissions received from companies requesting a drug addition to the NIDPF are reviewed by the Division to confirm that they are in compliance with the *Regulations*. The Division uses a checklist to ensure the completeness of the review process, which was developed based on the *Regulations*. If a submission does not comply, the manufacturer is advised to amend the submission to conform to the regulations and to resubmit.

For drug submissions that are in compliance with the *Regulations*, the submission package is reviewed within one of three review processes: administrative review, standard review, and expert review. The review process required for a particular drug submission is based on criteria set out in the Division's policy manual.

During the period of our review, there were 1,139 drugs added to the NIDPF. We chose a sample of 40 drugs that were added to the NIDPF to confirm that their inclusion on the NIDPF was in compliance with the *Regulations*.

Our review indicated the following:

Drug Submission Checklist

The Division's Listing and Delisting policy requires the use of a submission checklist to evaluate a drug submission. We reviewed the checklist and compared it to the *Regulations* to confirm completeness of the checklist against the *Regulations*. Examples of the *Regulations* requirements are:

- *a list of the applicable Heath Canada guidance documents on the assessment of bioavailability and bioequivalence of the drug;*

- *confirmation that the drug will be sold at the maximum price established under section 5...;* and

- *the quoted price for the drug, which shall be quoted in smallest unit pricing irrespective of package size.*

We determined that the drug submission checklist was complete as compared to the requirements of the *Regulations*.

We reviewed the completed drug submission checklists for the 40 drug additions chosen as samples and determined that the checklists were accurately and fully completed.

Findings

27. The drug submission checklist used by the Division during the period of our review included the drug addition requirements of the *Interchangeable Drug Products Formulary Regulations*.

28. The completed drug submission checklists we reviewed for 40 drug additions to the NIDPF contained all required information.

Review Process

Following the completion of the drug submission checklist, each submission is reviewed based on criteria set out in the Division's policy manual.

According to the Division's Listing and Delisting policy, there are two review processes: Minister Review and Advisory Committee Review.

The Minister Review, or Administrative Review, is used for drug submissions that are forwarded directly to the Minister for approval. According to the NLPDP policy manual, the following drugs are subject to an Administrative Review:

- *an ultra-generic drug,*
- *a cross licensed drug where the other drug is currently listed in the NIDPF,*
- *a drug with a Canadian Reference Product to a generic drug that had not previously been submitted or reviewed for inclusion in the NIDPF, or*
- *a drug with a Canadian Reference Product to a brand name product.*

The Advisory Committee Review has two levels of review: Standard review and Expert Review.

According to the NLPDP policy manual, the following drugs are subject to a Standard Review Process:

- *a drug with a Canadian Reference Product to a generic drug that has either been rejected from inclusion in the NIDPF or removed from the NIDPF for any reason,*

- *a drug with a Canadian Reference Product to a non-Canadian Reference Product, or*

- *a drug which has been sent to the Minister via Administrative Review but the Minister determines it should be reviewed in accordance with a Standard Review Process.*

According to the NLPDP policy manual, the following drugs are subject to an Expert Review Process:

- *a drug without a Canadian Reference Product which is not*

    - *an ultra-generic drug, or*

    - *a cross licensed drug with another drug currently listed on the NIDPF*

- *a drug referred for an Expert Review Process as a result of concerns identified in the Standard Review Process, or*

- *a drug which the Minister determines should be reviewed in accordance with an Expert Review Process.*

We determine that for the 40 drug additions to the NIDPF we reviewed, the level of review chosen and completed was in compliance with policy.

Finding

29. The level of review completed for the 40 additions to the NIDPF that we tested was appropriate.

4B. Pricing of Drugs on the NIDPF

Introduction

The price of generic drugs on the NIDPF is based on the price of the therapeutically equivalent brand name drug. Section 5.(1) of the *Regulations* outlines the following requirements:

- From April 1, 2013 to June 30, 2013, the maximum price a generic drug can be is 35% of the brand price; and

- From July 1, 2013 onward, the maximum price a generic drug can be is 25% of the brand price.

There are instances where drug manufacturers are unable to meet the established pricing requirements. In these cases, the manufacturers can apply for a pricing exemption. Section 6.(1) of the *Regulations* specifies that exemptions may be granted under the following conditions:

- *The brand name product has been discontinued; or*

- *In the opinion of the Minister, the applicant has incurred extraordinary production, manufacturing or development costs for the drug as demonstrable to the satisfaction of the Minister.*

There were approximately 4,700 drugs listed on the NIDPF as at September 30, 2014.

Our review indicated the following:

NIDPF Pricing

We reviewed the NIDPF that was effective as at September 30, 2014. We calculated the maximum price allowable for each category of generic drugs. We then compared the generic drug prices on the NIDPF to the maximum allowable price.

We determined that the pricing of drugs on the NIDPF was in accordance with the *Regulations*.

Finding

30. The pricing of drugs on the NIDPF during the period of our review was in accordance with the *Interchangeable Drug Products Formulary Regulations*.

Recommendations

1. The Department should determine whether the Medigent system refill business rule can be activated to prevent the reimbursement of claims that exceed the maximum refills authorized or determine some other course of action to prevent disallowed reimbursements from occurring.

2. The Department should determine whether modifications to the Medigent system can reduce the risk of unauthorized claims and payment of inappropriate professional fees from compound claims and prescription splitting.

3. The Department should develop a formal monitoring process of the Medigent system business rules to ensure that the rules continue to operate effectively subsequent to implementation.

4. The Department should develop policies and procedures to guide the audits performed by the Audit Services Section to ensure the audits are in compliance with legislation and the CPA Canada Handbook.

5. The Department should ensure that information is available to Providers regarding their role in the audit process.

6. The Department should ensure that requirements of the CPA Canada Handbook regarding audit planning, supervision, and review are met and there is documentation in the audit files to provide evidence that these requirements are met.

7. The Department should ensure that an annual report is prepared by the Audit Services Section for each fiscal year to ensure compliance with the *Pharmaceutical Services Act*.

8. The Department should ensure that the volume of audits of the NLPDP is sufficient and the audits are completed within a reasonable timeframe.

9. The Department should ensure that the status of audit findings are being tracked for monitoring purposes to ensure the complete recovery of amounts pertaining to claims errors.

10. The Department should accumulate information from audit results to determine whether there are widespread misinterpretations of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers.

Department Response

Recommendation 1: *The Department should determine whether the Medigent system refill business rule can be activated to prevent the reimbursement of claims that exceed the maximum refills authorized or determine some other course of action to prevent disallowed reimbursements from occurring.*

Department's Response:
The Department has experienced issues with claim processing performance with the current adjudication rule associated with refills. As a result, the refill adjudication rule in the system was disabled. The Department will work with the vendor for the adjudication system and implement a quantity check for refills in a manner that addresses the limitations identified with the current refill adjudication rule.

Recommendation 2: *The Department should determine whether modifications to the Medigent system can reduce the risk of unauthorized claims and payment of inappropriate professional fees from compound claims and prescription splitting.*

Department's Response:
Compounding
The process for receiving and adjudicating claims from pharmacies utilizes a national standard for the data that must be transmitted between the pharmacies and the adjudication system (the CPHA claim standard). A limitation of that standard is it can only accept one drug product per claim. This means that under the current claim standard it is impossible to submit multiple ingredients for a compound to the system for the individual adjudication of each ingredient. This limitation is shared by any drug plan (private or public) utilizing the CPHA claim standard, which is the primary claim standard in the Canadian pharmacy market.

Working within this limitation, the approach taken has been to allow pharmacies to calculate the cost of all the ingredients within the compound (using defined costs for each ingredient) to determine the total cost of the compound, and this is the value paid by the adjudication system. These are understood by pharmacies to be subject to audit, given the nature of the adjudication process.

This issue cannot be fully addressed without a change to the data standards used for drug claim adjudication that allow multiple ingredients to be submitted and adjudicated as a part of a single claim. The Department is a participant in national working groups (comprised of public and private drug plans) to develop a new drug claim standard. The adjudication of compounds has been identified as one of the areas of interest to be addressed in any new standard.

Split Prescriptions
The Department will work with the vendor for the adjudication system to determine if the adjudication rules related to days supply of medication can be modified to reduce the risk of unauthorized claims and payment of inappropriate professional fees from prescription splitting.

Recommendation 3: *The Department should develop a formal monitoring process of the Medigent system business rules to ensure that the rules continue to operate effectively subsequent to implementation.*

Departments' Response:
The Department will work with the vendor for the adjudication system to develop a structured monitoring process under which a number of claims will be sampled from the live adjudication system on a scheduled basis and the adjudication results for claims assessed to ensure the correct results are returned.

Recommendation 4: *The Department should develop policies and procedures to guide the audits performed by the Audit Services Section to ensure the audits are in compliance with legislation and the CPA Canada Handbook.*

Department's Response:
The Department is aware of the deficiencies with regards to written policies and procedures and is working towards addressing this issue. The Department will ensure the policies and procedures are in compliance with legislation and the CPA Canada Handbook.

Recommendation 5: *The Department should ensure that information is available to Providers regarding their role in the audit process.*

Departments' Response:
The Department is working towards the development of audit policies and procedures for the NLPDP Provider Guide. Part of this process has involved significant discussion and collaboration with the Pharmacy Association of Newfoundland and Labrador (PANL). When audit policies and procedures and related Regulations are finalized the Department will work with PANL to ensure providers have access to all relevant information so they understand their role in the audit process.

Recommendation 6: *The Department should ensure that requirements of the CPA Canada Handbook regarding audit planning, supervision, and review are met and there is documentation in the audit files to provide evidence that these requirements are met.*

Department's Response:
The Department will endeavor to ensure audit files document all requirements with respect to audit planning, supervision, and review in accordance with the CPA Canada Handbook.

Recommendation 7: *The Department should ensure that the annual report is prepared by the Audit Services Section for each fiscal year to ensure compliance with the* Pharmaceutical Services Act.

Department's Response:
The NLPDP audit report for the year ended March 31, 2014 is currently in process. The Department will ensure an annual report is completed.

Recommendation 8: *The Department should ensure that the volume of audits of the NLPDP is sufficient and the audits are completed within a reasonable timeframe.*

Department's Response:
The Department has experienced significant delays with the audit program of NLPDP. However, considerable effort has been made in recent months to finalize the audit policies and procedures as well as the Audit & Recovery Regulations under the Pharmaceutical Services Act. *When the audit policies and the Regulations are implemented the Department will re-focus its attention on the volume of audits of the NLPDP and on ensuring audits are completed within a reasonable timeframe.*

Recommendation 9: *The Department should ensure that the status of audit findings are being tracked for monitoring purposes to ensure the complete recovery of amounts pertaining to claims errors.*

Department's Response:
The Department has started to track and document the status of audit findings which are used to monitor pattern and trends in billing errors. The Department will also ensure audit findings are tracked to ensure complete recovery of amounts pertaining to claims errors.

Recommendation 10: *The Department should accumulate information from audit results to determine whether there are widespread misinterpretations of guidance within the Provider Guide or incorrect billings and patterns of incorrect billings by particular Providers.*

Department's Response:
The Department recognizes the need for improved reporting for analysis and review of the program. Summary reports on the nature and frequency of billing errors have already been implemented. These summary reports will form the basis of an ongoing database of billing errors which will be used to monitor patterns or trends over time. Longer term goals will see the development of standardized statistical reporting and data extraction tools similar to those available for MCP fee-for-service audit purposes.

PART 3.6

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

NUTRITION IN LONG-TERM CARE FACILITIES

Summary

Introduction

As at March 31, 2014, the regional health authorities (RHAs) administered 41 facilities with 2,788 long-term care beds available. Of these 41 facilities, 25 are publicly-operated long-term care facilities which provide residential care and accommodations to 2,390 long-term care residents who have high care needs and require on-site services. The remaining 398 long-term care residents are cared for in 15 publicly-operated acute-care facilities (i.e. health care centres and hospitals) and one private facility.

The *Regional Health Authorities Act (the Act)* outlines the responsibilities of the Department of Health and Community Services (the Department) and RHAs. The *Act* states that the Minister may determine standards for the provision of health and community services by an RHA. In November 2005, the Department developed the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador (the Standards). The Standards state that nutritional services provided by long-term care facilities should be designed to provide safe, nutritious and quality meals to meet the nutritional, therapeutic and social needs of residents.

Objectives

The objectives of our review were to determine whether the:

1. Department and RHAs have established operational standards, policies and procedures which provide for the planning, delivery and monitoring of food services provided to residents;

2. RHAs adequately plan and allocate resources for providing safe and nourishing meals to residents;

3. RHAs provide safe and nourishing meals to residents; and

4. Department and RHAs monitor and report on food services provided to residents of long-term care facilities.

Scope

Our review covered the fiscal year ended March 31, 2014 and the ten-month period ended January 31, 2015. Our review included an examination of Department and RHA policies and procedures, statistical and financial information, meal plans, resident assessments, health inspection reports, occurrence reports, and other relevant documents, and included interviews with Department and RHA officials.

Our review included long-term care facilities operated by the Eastern and Western RHAs and included site visits to a sample of five long-term care facilities. Our review also included a review of health records for 55 residents.

We completed our review in February 2015.

Use of Expert

Our review used the services of a registered dietitian to review menu plans from each facility visited and to provide general advice.

Conclusions

Objective 1

The Department has developed Operational Standards for Long Term Care Facilities in Newfoundland and Labrador (the Standards) and RHAs have established policies and procedures which provide for the planning, delivery and monitoring of food services provided to residents, however, the Standards have not been periodically reviewed to ensure the Dietitians of Canada's *"Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes"* have been incorporated. In addition, RHA policies and procedures were not always consistent with the Standards established by the Department or consistent between the RHAs reviewed.

Objective 2

The two RHAs we reviewed had established policies and procedures for providing safe and nourishing meals to residents, however, regular assessments of residents for determining dietary needs were not always performed and meal plans were not always prepared in accordance with Canada's Food Guide or in accordance with a resident's dietary assessments.

Objective 3

For the five long-term care facilities we examined, the two RHAs generally provided safe and nourishing meals to residents, however, we identified issues with food safety, the provision of meals to residents, and the supervision of residents while eating.

Objective 4

The Department and RHAs had processes in place to monitor and report on food services provided to residents of long-term care facilities. However, for the RHAs and long-term care facilities in our sample, issues were identified in the RHAs' quality improvement processes related to process audits, complaints reporting and occurrence reporting. In addition, the Department and RHAs did not establish performance indicator benchmarks.

Findings

Operational Standards, Policies and Procedures

Departmental Operational Standards

1. The Department did not conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador every two years, as required, to ensure the Standards reflect best practices or current processes. As a result, RHAs have established policies and procedures to reflect current practice without guidance from the Department. This has resulted in inconsistent policies and procedures between the two RHAs reviewed and with the Standards.

2. The Operational Standards for Long Term Care Facilities in Newfoundland and Labrador did not always reflect best practices as identified in the Dietitians of Canada's "*Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes*". The Standards also lacked detail in certain areas which could lead to different interpretations by RHAs and inconsistencies in policies and procedures set by RHAs.

RHA Policy and Procedures

3. For the two RHAs examined, policies and procedures on food and nutrition services were not always in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

Planning of Safe and Nourishing Meals

Assessment of Residents

4. For the sample of resident files we reviewed, admission checklists were not always completed, were not always completed in full or were not always on file.

5. For the sample of resident files we reviewed, resident care plans were not always completed or reviewed quarterly as required.

6. For the sample of resident files we reviewed, a Resident Assessment Instrument-Minimum Data set 2.0 assessment tool which is used to gather information on a resident's strengths, needs and preferences was not always completed upon admission or reviewed quarterly as required.

7. For the sample of resident files we reviewed, interdisciplinary team conferences, which are held between the resident's health care team, the resident and their family to assess the needs of the resident, were not always held or not always held within the required timeframe.

8. The Eastern RHA did not have a formal policy on feeding assessments which can be used to assess a resident's feeding capabilities and whether a referral to a dietitian or a therapist was necessary to address any feeding issues.

9. For the sample of resident files we reviewed at the Western RHA's long-term care facilities we visited, eight of the 25 residents did not always have quarterly feeding screens done and two of these eight residents did not have initial feeding screens completed upon admission. As a result, residents with feeding issues may not have been identified and followed up on.

10. For the two RHAs we reviewed, the RHAs had inconsistent policies for assessing and following up on unplanned resident weight changes.

11. For the sample of resident files we reviewed, residents were not always weighed upon admission or monthly in accordance with the respective RHAs' policy. As a result, unplanned changes in a resident's weight outside of established thresholds would not be identified in a timely manner.

12. Two of the five long-term care facilities we reviewed did not have a system in place to readily identify residents that had unplanned weight changes outside of established thresholds to ensure timely and adequate follow-up was initiated.

13. For the sample of resident files we reviewed, assessments by a registered dietitian were not always completed as required by the Standards or RHA policy.

14. The St. John's Long-term Care facility was not always assessing residents on a quarterly basis for the risk of pressure ulcers as required by RHA policy.

Menus and Meal Plans

15. For two long-term care facilities we reviewed, master menus were not always reviewed and revised annually by a registered dietitian as required.

16. For four long-term care facilities we reviewed, master menus did not provide residents with the recommended daily food servings for each of the four food groups established by Canada's Food Guide.

17. Insufficient information was available to perform an analysis on the master menu of the Glenbrook Lodge.

18. For four long-term care facilities we reviewed, the master menus did not always provide sufficient detail of the meals provided or did not always record what was actually being served to residents.

19. The RHAs reviewed did not have consistent processes and systems in place to ensure resident meal plans were provided in accordance with Canada's Food Guide, that dietary changes were tracked, that texture and other major diet changes (excluding preferences) made by nursing staff were reviewed and approved by a registered dietitian, and that meal tickets were provided with the meal to ensure meals were provided in accordance to the resident's dietary profile.

Provision of Safe and Nourishing Meals

Provision of a Safe and Clean Environment

20. For the five long-term care facilities we examined, kitchen and dining areas were observed to be clean and regular inspections were performed, however, our facility visits identified food safety issues related to food safety training, food temperatures, maintenance and cleaning schedules, food storage and food preparation.

21. For the five long-term care facilities examined, RHAs had hygienic practices in place but did not always perform hand hygiene training and audits in the kitchen to ensure the safety of food provided to residents.

Provision of Meals

22. The facilities we reviewed did not always have processes in place to ensure residents were being provided and consuming meals in accordance with their meal plans.

23. The St. John's Long-term Care facility did not provide meals to residents on a healthy heart diet in accordance with all the requirements of Eastern RHA's established diet standard.

24. For the sample of 52 residents, 28 were not always provided meals in accordance with their prescribed meal plans.

25. Although RHAs had policies and procedures for providing meals at the appropriate texture and temperature, our review of five long-term facilities identified issues where meals were not always provided at the proper texture and at the correct temperature and processes were not always present to ensure the texture and temperatures of meals were in accordance with RHA policy.

26. For the long-term care facilities examined, residents were not always supervised while eating in accordance with the Standards or RHA policy or a supervision policy was not documented.

27. For the long-term care facilities examined, nursing staff responsible for supervising residents while eating did not always receive annual training in foreign body obstruction.

Monitoring of Nutritional Services

Continuous Quality Improvement

28. The Standards did not specifically require audits to be performed as part of a RHAs' continuous quality improvement, and without direction from the Department, the two RHAs established different requirements for audits which resulted in audits being conducted inconsistently.

Complaints and Occurrences

29. Only the St. John's Long-term Care facility reported receiving complaints, however, Eastern RHA staff indicated that complaints were either reported verbally or through emails, but an official complaint form was not completed or tracked as required. As a result, we could not determine the true extent of complaints and whether the facility was responding to these complaints in accordance with RHA policy.

30. The long-term care facilities examined were not always addressing reported occurrences within the timeframes outlined in the RHAs' policy.

Financial and Statistical Data

31. The Department has not established benchmarks and variance thresholds for each performance indicator for the Province, for each RHA or for each long-term care facility. Without benchmarks or variance thresholds being established for each performance indicator, it is not possible for the Department or RHAs to compare actual results to expected results and determine which variances should be investigated.

32. The RHAs did not establish benchmarks and variance thresholds to be used for comparing actual to expected results of all performance indicators related to food services and nutrition services that were reviewed.

Recommendations

1. The Department should conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador as required.

2. The Eastern RHA and Western RHA should develop food and nutrition services policies and procedures consistent with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and consider working with the other RHAs and the Department to establish policies and procedures that are consistent across the Province.

3. The Eastern RHA and Western RHA should ensure resident assessments are completed as required in order to maintain a current dietary profile for each resident.

4. The Eastern RHA and Western RHA should ensure the nutritional contents of the master menus comply with Canada's Food Guide, and that master menus are regularly assessed by a registered dietitian.

5. The Eastern RHA and Western RHA should ensure a resident's meal plan is established in accordance with the resident's dietary assessment and that texture and other major diet changes (excluding preferences) are reviewed and approved by a registered dietitian as required by the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

6. The Eastern RHA and Western RHA should ensure food safety, food temperatures, food storage, food preparation and maintenance and cleaning schedules are monitored and in accordance with the *Food Premises Regulations*, the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and RHA policy.

7. The Eastern RHA and Western RHA should provide meals to residents in accordance with their prescribed meal plans and at the appropriate temperature.

8. The Eastern RHA and Western RHA should ensure residents are appropriately supervised during meals in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and applicable RHA policies.

9. The Eastern RHA and Western RHA should improve their quality improvement processes by ensuring that process audits, complaints reporting and occurrences reporting are conducted in accordance with applicable RHA policies and such policies are consistent across the Province.

10. The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data, including performance indicators, against these benchmarks and follow up significant variances.

Objectives, Scope and Use of Expert

The objectives of our review were to determine whether the:

1. Department of Health and Community Services (the Department) and Regional Health Authorities (RHAs) have established operational standards, policies and procedures which provide for the planning, delivery and monitoring of food services provided to residents;

2. RHAs adequately plan and allocate resources for providing safe and nourishing meals to residents;

3. RHAs provide safe and nourishing meals to residents; and

4. Department and RHAs monitor and report on food services provided to residents of long-term care facilities.

Scope

Our review covered the fiscal year ended March 31, 2014 and the ten-month period ended January 31, 2015. Our review included an examination of Department and RHA policies and procedures, statistical and financial information, meal plans, resident assessments, health inspection reports, occurrence reports, and other relevant documents, and included interviews with Department and RHA officials.

Our review included long-term care facilities operated by the Eastern and Western RHAs and included site visits to a sample of five long-term care facilities. Our review also included a review of health records for 55 residents. Table 1 outlines the long-term care facilities and the number of residents included in our sample at each facility included in our review.

Table 1

Nutrition in Long-term Care Facilities
Sample of Long-term Care Facilities and Residents
January 2015

Long-term Care Facilities	Location	Number of Residents	Resident Files Sampled
St. John's Long-term Care (Note 1)	St. John's	405	15
Salvation Army Glenbrook Lodge	St. John's	104	10
Dr. Albert O'Mahony Memorial Manor	Clarenville	44	5
Eastern RHA Total		**553**	**30**
Corner Brook Long-term Care Home	Corner Brook	236	15
Bay St. George Long-term Care Centre	Stephenville Crossing	114	10
Western RHA Total		**350**	**25**
Total		**903**	**55**

Note 1: Excludes 25 residents transferred from the Mental Health Program

We completed our review in February 2015.

Use of Expert

Our review used the services of a registered dietitian to review menu plans from each facility visited and to provide general advice.

Background

As at March 31, 2014, the RHAs administered 41 facilities with 2,788 long-term care beds available. Of these 41 facilities, 25 are publicly-operated long-term care facilities which provide residential care and accommodations to 2,390 long-term care residents who have high care needs and require on-site services. The remaining 398 long-term care residents are cared for in 15 publicly-operated acute-care facilities (i.e. health care centres and hospitals) and one private facility.

The *Regional Health Authorities Act (the Act)* outlines the responsibilities of the Department and RHAs. The *Act* states that the Minister may determine standards for the provision of health and community services by an RHA.

Nutrition in long-term care facilities has a significant impact on quality of life and is essential to the health of the resident of a long-term care facility. Proper nutritious food provided to residents can assist in better control over diseases related to the heart, blood pressure, stroke, dementia, and blood sugar levels, maintain adequate vision, and result in better recovery and healing.

Table 2 outlines the food service expenditures in long-term care facilities for the years ended March 31, 2013 and 2014 and the number of facilities and residents in each RHA as at March 31, 2014.

Table 2

Nutrition in Long-term Care Facilities
Overview of RHAs
For the Years Ended March 31

Regional Health Authority	Number of Long-term Care Facilities	Number of Residents	Expenditures	
			2013	2014
Eastern	15	1,525	$24,130,679	$25,337,377
Central	6	418	5,948,897	6,184,832
Western	2	350	5,164,487	5,471,003
Labrador-Grenfell	2	97	1,298,566	1,261,645
Total	**25**	**2,390**	**$36,542,629**	**$38,254,857**

Source: Department of Health and Community Services

Detailed Observations

1. Operational Standards, Policies and Procedures

Objective

To determine whether the Department and RHAs have established operational standards, policies and procedures which provide for the planning, delivery and monitoring of food services provided to residents.

Conclusion

The Department has developed Operational Standards for Long Term Care Facilities in Newfoundland and Labrador (the Standards) and RHAs have established policies and procedures which provide for the planning, delivery and monitoring of food services provided to residents, however, the Standards have not been periodically reviewed to ensure the Dietitians of Canada's *"Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes"* have been incorporated. In addition, RHA policies and procedures were not always consistent with the Standards established by the Department or consistent between the RHAs reviewed.

Our review considered whether:

- The Department had established operational standards for the planning, delivery and monitoring of nutrition and food services in accordance with best practices; and

- RHAs had established policies and procedures that were in accordance with operational standards developed by the Department.

1A. Departmental Operational Standards

Introduction

In November 2005, the Department developed the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador (the Standards). The Standards state that nutritional services provided by long-term care facilities should be designed to provide safe, nutritious and quality meals to meet the nutritional, therapeutic and social needs of residents. If provided properly, a resident will:

- receive the clinical nutrition intervention consistent with the residents' identified medical and nutritional needs; and

- be provided with an organized, dietetic service which responds to the residents' dietary requirements and enhances the quality of the residents' life.

Review of Standards

The Introduction to the Standards states that "*the standards will be reviewed and revised if necessary to incorporate new ideas that will support a standard that best meets the care, program and service needs of residents. This review may involve the participation of long-term care stakeholders and will occur every two years. These standards are subject to Departmental review and may be changed at the discretion of the Department.*"

The Standards were not reviewed every two years as required and have not been reviewed since being implemented in 2005. We found that RHAs have established policies and procedures which were based upon current practice and without guidance from the Department. This has resulted in inconsistent policies and procedures between the RHAs and with the Standards. For example:

- RHAs have policies on occurrence reporting for occurrences and have been using a clinical safety reporting system for documenting occurrences since 2012, however, the Standards did not provide any guidance or performance measures on occurrence reporting. As a result, the two RHAs reviewed had established different timeframes for finalizing the investigation of an occurrence.

- RHAs indicated that master menus, which are required to be accessible by residents, have not been posted as required by the Standards. The five long-term care facilities that we visited indicated that posting the full master menu, which covers three to four weeks, was confusing to residents and served little purpose. The two RHAs we reviewed, required that only the current day of the master menu be posted.

- RHAs have policies and procedures on food safety during preparation to ensure cooking temperatures are in accordance with the *Food Premises Regulations,* however, the Standards did not make reference to these temperature requirements.

Finding

1. The Department did not conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador every two years, as required, to ensure the Standards reflect best practices or current processes. As a result, RHAs have established policies and procedures to reflect current practice without guidance from the Department. This has resulted in inconsistent policies and procedures between the two RHAs reviewed and with the Standards.

Best Practices

We reviewed the Standards, as they related to food services and nutrition services, to determine whether they were in accordance with best practices used within the health care industry. We compared the Standards with the Dietitians of Canada's "*Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes"* (Dietitians of Canada Best Practices) which was published in 2007 and revised in April 2013. The Department indicated that although the document is recognized as a guiding document for best practices in long-term care, it had not adopted it for implementation in the Province's long-term care facilities. Our review identified the following issues:

- The Standards lacked sufficient detail when compared to the Dietitians of Canada Best Practices. For example, the Dietitians of Canada Best Practices provided detailed information on the minimum processes involved in nutritional assessments and reassessments and the development of standardized recipes, whereas the Standards provided general performance measures for these items. This lack of detail may result in inconsistent policies being developed by RHAs.

- The Standards were not always consistent with best practices provided in the Dietitians of Canada Best Practices. For example, best practices indicated that:

    - menus should cover a three to four week cycle period whereas the Standards indicated a minimum of six weeks;

    - a registered dietitian should review and approve the menu, however, the Standards did not require this; and

    - dietary needs should be assessed in accordance with both Canada's Food Guide and the Dietary References Intakes documents, however, the Standards only referenced Canada's Food Guide.

Finding

2. The Operational Standards for Long Term Care Facilities in Newfoundland and Labrador did not always reflect best practices as identified in the Dietitians of Canada's "*Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes*". The Standards also lacked detail in certain areas which could lead to different interpretations by RHAs and inconsistencies in policies and procedures set by RHAs.

1B. RHA Policy and Procedures

Introduction

RHAs are responsible for developing and implementing policies and procedures that ensure food and nutritional services are provided in accordance with the Standards. We examined the policies and procedures for the Eastern and Western RHAs for compliance with the Standards on such items as clinical nutrition, food services, integrated care plans, complaints, and continuous quality improvement.

Compliance with Operational Standards

Our review of the two RHAs identified that policies and procedures were not always in place or in accordance with the Standards. For example:

Eastern RHA

- The Standards require that clinical nutrition services are to be provided by a registered dietitian within eight weeks of admission, however, RHA policy states that nursing staff are required to evaluate residents upon admission and the services of a registered dietitian are only needed upon referral made by the resident, family members or another member of the interdisciplinary team.
- There were no policies or procedures governing the delivery of clinical nutrition services by registered dietitians.
- Eleven of the 15 long-term care facilities provided food services to residents through externally contracted food service companies. The remaining four long-term care facilities provided food services to residents using RHA employed staff. The Eastern RHA did not have food services policies and procedures to ensure consistency between the four long-term care facilities. Consequently, there were either no food services policies or procedures or there were only site-specific policies and procedures at these four long-term care facilities.
- There was no policy governing the supervision of residents in dining areas during meals by nursing staff.

Western RHA

- RHA policy requires that an interdisciplinary conference be held with the resident within 10 weeks of admission, however, the Standards state eight weeks.
- RHA policy requires management to acknowledge the receipt of a complaint to a complainant within five days, however, the Standards require two days.
- There was no policy requiring the provision of afternoon snacks. RHA staff indicated that floor stock is available upon a resident's request.

If RHAs are not establishing policies and procedures in accordance with the Standards, it could create an environment where the Standards are not being followed or inconsistent practices are being implemented.

Finding

3. For the two RHAs examined, policies and procedures on food and nutrition services were not always in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

2. Planning of Safe and Nourishing Meals

Objective

To determine whether RHAs adequately plan and allocate resources for providing safe and nourishing meals to residents.

Conclusion

The two RHAs we reviewed had established policies and procedures for providing safe and nourishing meals to residents, however, regular assessments of residents for determining dietary needs were not always performed and meal plans were not always prepared in accordance with Canada's Food Guide or in accordance with a resident's dietary assessments.

Our review considered whether:

- Each resident's dietary needs and requirements were assessed quarterly and documented in the residents' care plan; and
- Meal plans were developed in accordance with nutritional standards (i.e. Canada's Food Guide) and individual nutritional assessments.

2A. Assessment of Residents

Introduction

Residents are assessed upon admission to a long-term care facility and periodically reassessed to determine their dietary needs. An interdisciplinary team involved in a resident's care may include a social worker, registered dietitian, nurse, physician, occupational therapist, speech language pathologist, recreational therapist and resident care coordinator/manager that are responsible for the assessment of residents. Assessments related to the dietary needs involve resident care plan reviews, assessments tools, interdisciplinary team conferences and weight assessments.

Admission Checklists

An admission checklist is prepared for each resident to ensure a resident is assessed completely upon admission. Of the 55 residents' files we reviewed, 27 residents were admitted after April 1, 2013, the beginning of our review period. We examined these 27 files to determine if an admission checklist was completed. We identified the following:

<u>Eastern RHA</u>

St. John's Long-term Care facility

- Admission checklists were completed for all eight residents reviewed.

Glenbrook Lodge
- We could not review the admission checklists for four residents because the checklists were not retained after completion.

Dr. Albert O'Mahony Memorial Manor
- For the three resident files we reviewed, admission checklists were not completed because checklists were not required to be completed for residents transferred from another facility.

Western RHA

Corner Brook Long-term Care Home, we reviewed seven admission checklists and found:
- Three admission checklists were completed;
- Three admission checklists were not completed in full; and
- One admission checklist was not on file.

Bay St. George Long-term Care Centre
- Three of five admission checklists reviewed were not completed in full.

Finding

4. For the sample of resident files we reviewed, admission checklists were not always completed, were not always completed in full or were not always on file.

Resident Care Plans

Once a resident is admitted, a resident care plan is initiated within 24 hours and completed once an interdisciplinary team conference is held within eight weeks. The resident care plan addresses all aspects of a resident's needs and goals, including food and dietary. The Standards require that resident care plans be reviewed and updated at least quarterly. Our review identified that resident care plans were not always completed and quarterly reviews were not always documented as required:

Eastern RHA

St. John's Long-term Care facility
- 45 of 54 required quarterly reviews for the nine residents reviewed were not completed; and
- Three residents who were admitted between July and September 2014 did not have their plans completed as of January 30, 2015.

Glenbrook Lodge
- 10 of 14 required quarterly reviews for the two residents reviewed were not completed.

Dr. Albert O'Mahony Memorial Manor
- One of the 14 required quarterly reviews for one resident reviewed was not completed; and
- One of the 14 required quarterly reviews for one resident reviewed was completed late by two months.

Western RHA

Corner Brook Long-term Care Home
- 48 of 77 required quarterly reviews for the 13 residents reviewed were not completed.

Bay St. George Long-term Care Centre
- 13 of 34 required quarterly reviews for the five residents reviewed were not completed.

Finding

5. For the sample of resident files we reviewed, resident care plans were not always completed or reviewed quarterly as required.

MDS Assessments

RHAs use a computerized assessment tool known as the Resident Assessment Instrument-Minimum Data set 2.0 (MDS) which is used to gather information on a resident's strengths, needs and preferences which are subsequently integrated into the resident care plan. The MDS assessment is to be completed on admission and on a quarterly basis by the interdisciplinary team. We found that MDS assessments were not always completed as required:

Eastern RHA

St. John's Long-term Care facility
- Three quarterly assessments for three residents reviewed were drafted but not completed; and
- One quarterly assessment was not completed for one of the 15 resident files we reviewed.

Glenbrook Lodge
- The facility did not have access to the electronic MDS assessment tool until November 2014, therefore MDS assessments were not conducted until then. In February 2012, Eastern RHA policy indicated that access to the MDS assessment tool for all long-term care facilities would be phased in over time, however, it was almost three years before Glenbrook Lodge received access.

Dr. Albert O'Mahony Memorial Manor
- All quarterly assessments were completed for the five resident files we reviewed.

Western RHA

Corner Brook Long-term Care Home
- Two quarterly assessments were not completed for two of the 15 resident files reviewed; and
- 17 quarterly assessments were late from one to two months related to 10 of 15 resident files we reviewed.

Bay St. George Long-term Care Centre
- Three quarterly assessments were late by one month for three of the ten resident files reviewed.

Finding

6. For the sample of resident files we reviewed, a Resident Assessment Instrument-Minimum Data set 2.0 assessment tool which is used to gather information on a resident's strengths, needs and preferences was not always completed upon admission or reviewed quarterly as required.

Interdisciplinary Team Conferences

The Standards require an interdisciplinary team conference to be held between the team and the resident and their family within eight weeks of a resident's admission and, thereafter, as required. Of the 55 residents we reviewed, 27 residents were admitted after Apri1 1, 2013, the beginning of our review period. We examined these 27 resident files to determine if an interdisciplinary team conference was held within eight weeks of admission.

Our review identified that interdisciplinary team conferences were either not always held or not always held within the required timeframe as follows:

Eastern RHA

St. John's Long-term Care facility
- Two conferences were held within the eight week timeframe; and
- Six conferences were held from one week to 20 weeks beyond the eight week timeframe.

Glenbrook Lodge
- Two conferences were held within the eight week timeframe; and
- Two conferences were held from one week to six weeks beyond the eight week timeframe.

Dr. Albert O'Mahony Memorial Manor
- Three conferences were held from six weeks to 26 weeks beyond the eight week timeframe.

Western RHA

Corner Brook Long-term Care Home
- Six conferences were held from four weeks to 39 weeks beyond the eight week timeframe; and
- One conference had not been held for one resident admitted on May 7, 2014.

Bay St. George Long-term Care Centre

- Two conferences were held from five weeks to 15 weeks beyond the eight week timeframe; and
- Three conferences were not yet due.

The Western RHA also required annual interdisciplinary team conferences to be held, however, 11 of the 14 resident files that we examined did not have an annual conference in 2014. None of the eight residents that we reviewed at the Corner Brook Long-term Care Home had an annual conference held during 2014 and three of the six residents that we reviewed at the Bay St. George Long-term Care Centre did not have an annual conference held during 2014.

Finding

7. For the sample of resident files we reviewed, interdisciplinary team conferences, which are held between the resident's health care team, the resident and their family to assess the needs of the resident, were not always held or not always held within the required timeframe.

Feeding Assessments

The Western RHA uses an assessment tool known as a feeding screen to assess a resident's feeding and whether a referral to a dietitian or a therapist is necessary to address any feeding issues. The required feeding screens are to be performed within 24 hours of admission and quarterly thereafter (annually prior to March 31, 2014) by a registered nurse.

The Eastern RHA did not have a formal policy on feeding screens and indicated that residents were assessed informally and referrals were made where necessary.

Our review identified the following issues:

Eight of the 25 resident files we reviewed at the Western RHA did not have feeding screens done within 24 hours of admission and/or quarterly. Specifically:

Corner Brook Long-term Care Home

- One resident did not have an initial feeding screen completed until 16 days after admission and did not have one of four quarterly feeding screens completed.

Bay St. George Long-term Care Centre

- Seven residents did not have 10 of 20 quarterly feeding screens completed and one of the seven residents did not have an initial feeding screen done upon admission.

Findings

8. The Eastern RHA did not have a formal policy on feeding assessments which can be used to assess a resident's feeding capabilities and whether a referral to a dietitian or a therapist was necessary to address any feeding issues.

9. For the sample of resident files we reviewed at the Western RHA's long-term care facilities we visited, eight of the 25 residents did not always have quarterly feeding screens done and two of these eight residents did not have initial feeding screens completed upon admission. As a result, residents with feeding issues may not have been identified and followed up on.

Weight Assessments

Residents are required to be weighed upon admission and then weighed monthly. If a resident experiences an unplanned weight change outside certain thresholds, a referral to a dietitian is made for a follow-up review.

The two RHAs reviewed had inconsistent policies on weight assessments. The Eastern RHA required a referral be made to a registered dietitian if there was an unplanned weight change of 5% in one month, while the Western RHA's policy required a referral to a registered dietitian if there was an unplanned weight change of 5% in one month, 7.5% over three months or 10% over six months or if a resident's weight dropped below 40 kilograms.

From our sample of 55 resident files, 14 residents were not weighed in accordance with the respective RHAs' policy as follows:

<u>Eastern RHA</u>

St. John's Long-term Care facility
- Three residents were not weighed upon admission; and
- Three residents were not weighed monthly after admission, with gaps ranging from two months to five months.

Glenbrook Lodge
- One resident was not weighed for two consecutive months in 2013.

<u>Western RHA</u>

Corner Brook Long-term Care Home
- Two residents were not weighed upon admission; and
- Seven residents were not weighed monthly after admission, with gaps ranging from two months to four months. Two of these residents were not weighed monthly during periods of significant weight loss.

The Corner Brook Long-term Care Home and the Bay St. George Long-term Care Centre did not have a system in place to readily identify residents that had unplanned weight changes outside of established thresholds to assist nursing staff and registered dietitians in monitoring the weight of residents in accordance with policy.

Findings

10. For the two RHAs we reviewed, the RHAs had inconsistent policies for assessing and following up on unplanned resident weight changes.

11. For the sample of resident files we reviewed, residents were not always weighed upon admission or monthly in accordance with the respective RHAs' policy. As a result, unplanned changes in a resident's weight outside of established thresholds would not be identified in a timely manner.

12. Two of the five long-term care facilities we reviewed did not have a system in place to readily identify residents that had unplanned weight changes outside of established thresholds to ensure timely and adequate follow-up was initiated.

Assessments by Registered Dietitians

The Standards require that a registered dietitian be a member of the interdisciplinary team and therefore required to assess the dietary needs of each resident based on a nutritional assessment and preferences within eight weeks upon admission. The registered dietitian is also required to assess residents upon requests and referrals made by the resident, family members or another member of the interdisciplinary team. Our review identified the following:

Eastern RHA

Eastern RHA's policy provides for assessments by a registered dietitian by referral only and does not require annual reviews to be performed. As a result, residents were not being assessed by a registered dietitian for extended periods of time as follows:

St. John's Long-term Care facility

- Four of the 15 residents that we reviewed did not have an assessment done, ranging from one year to almost two years, as no referrals had been made.

Glenbrook Lodge

- Three of the 10 residents that we reviewed did not have an assessment done, ranging from one year to almost two years, as no referrals had been made.

Dr. Albert O'Mahony Memorial Manor

- One of the five residents that we reviewed did not have an assessment done for over a year as no referrals had been made.

Western RHA

Western RHA's policy requires registered dietitians to perform an annual review if no referrals were made for a resident. We identified the following:

Corner Brook Long-term Care Home

- Three of the 15 residents that we reviewed did not have any referrals and were not assessed on an annual basis.
- Two residents that were referred for an assessment were not assessed for periods ranging from 24 to 29 days after the required timeframe.

Bay St. George Long-term Care Centre

- Two of the 10 residents that we reviewed did not have any referrals and were not assessed on an annual basis.

Finding

13. For the sample of resident files we reviewed, assessments by a registered dietitian were not always completed as required by the Standards or RHA policy.

Wound Assessments

RHAs are required to assess residents for pressure ulcers on initial assessment and quarterly thereafter using the Braden Scale, a standardized risk assessment tool. Assessing a resident's risk in this area is important in developing a proper dietary plan to prevent or heal pressure ulcers.

Our review indicated that the St. John's Long-term Care facility did not conduct 14 quarterly assessments for 7 of 15 residents reviewed. We note that the St. John's Long-term Care facility's electronic clinical documentation database, which was in use since March 2014, did not automatically create due dates for the Braden Scale assessments, and may have contributed to assessments not being done. The other four long-term care facilities that we reviewed were properly assessing residents on a quarterly basis.

Finding

14. The St. John's Long-term Care facility was not always assessing residents on a quarterly basis for the risk of pressure ulcers as required by RHA policy.

2B. Menus and Meal Plans

Introduction

Canada's Food Guide is a nutrition guide produced by Health Canada. Health Canada indicated the overall purpose of dietary guidance is to identify and promote a pattern of eating that meets nutrient needs and reduces the risk of nutrition-related chronic diseases such as obesity, diabetes, cancer and cardiovascular disease. Canada's Food Guide provides recommended daily servings for four food groups including milk and alternatives; meat and alternatives; vegetables and fruit; and grain products. Table 3 provides an overview of Canada's Food Guide recommendations.

Table 3

Nutrition in Long-term Care Facilities
Canada's Food Guide
Recommended Food Servings per Day

Food Group	Recommended Servings for Adults 51 and Older	
	Females	Males
Milk and Alternatives	3	3
Meat and Alternatives	2	3
Vegetables and Fruit	7	7
Grain Products	6	7
Other Recommendations		
1. At least one dark green and one orange vegetable/fruit offered daily.		
2. Whole grain products offered daily.		
3. 500 ml (2 cups) of milk offered daily for adequate vitamin D.		
4. At least two servings of fish offered weekly.		

Source: Heath Canada

Master Menus

Each long-term care facility has a master menu which provides the daily menu for residents. The Standards require menus and meals to be provided according to Canada's Food Guide and that residents have access to a planned, date-cycled, posted master menu covering a minimum period of six weeks. In addition, residents are to be offered a minimum of three meals per day, beverages with meals, between meals and at bedtime, and snacks in mid-afternoon and at bedtime. Our review of the master menus for the five facilities identified the following issues:

- Master menus were required to be reviewed and revised annually by a registered dietitian. Our review indicated that:

    - The Bay St. George Long-term Care Centre, Corner Brook Long-term Care Home and St. John's Long-term Care facility indicated that master menus were reviewed regularly throughout the year by a registered dietitian;

    - The Dr. Albert O'Mahony Memorial Manor indicated the master menu was reviewed every two years by a registered dietitian; and

    - The Glenbrook Lodge indicated that the master menu was reviewed annually but not by a registered dietitian.

    These reviews were not documented and any changes made to the menu were also not documented to support that the master menus were in accordance with Canada's Food Guide. The St. John's Long-term Care facility indicated that the master menu was assessed by a registered dietitian using a nutrient assessment tool because their dietary management database provided this information but no analysis was provided to support if their menu was in accordance to Canada's Food Guide.

- None of the five facilities visited had the complete master menu posted. Four facilities had the master menu posted for the current day which was accessible by residents and staff. The St. John's Long-term Care facility did not have the daily master menu posted for four months since the opening of the facility in September 2014.

Analysis of Master Menus

Our Office engaged the services of a registered dietitian to analyze the master menu for each of the five facilities for a one week period to determine if the menus met the requirements of Canada's Food Guide.

The Glenbrook Lodge's master menu and supporting documentation was inadequate for an analysis to be performed by the consulting registered dietitian due to the following concerns:

- The facility's week 3 menu listed three to four choices for certain meals which were served based upon the cook's selection for a particular day. Therefore it would be difficult to determine which food items were being served consistently to residents on any given day.

- Standardized recipes were not provided for all menu items served. Without the use of standardized recipes, food items could be produced inconsistently, and difficult to analyze.

- Portion sizes provided were inconsistent between similar foods. A portion size chart was not provided which indicated it was not being used at this facility. Without the use of an accurate portion control chart, the quantity of food items served to the residents could be inconsistent.

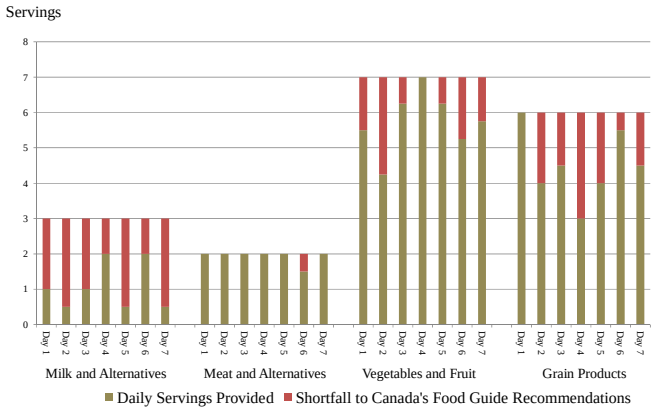
- There were numerous highly processed food items which were being served on the menu daily. Canada's Food Guide recommends limiting foods of this nature which are high in calories, fat, and sodium and are not recommended as part of a high quality healthy diet.

Figure 1 provides the results of the analysis for the remaining four long-term care facilities examined.

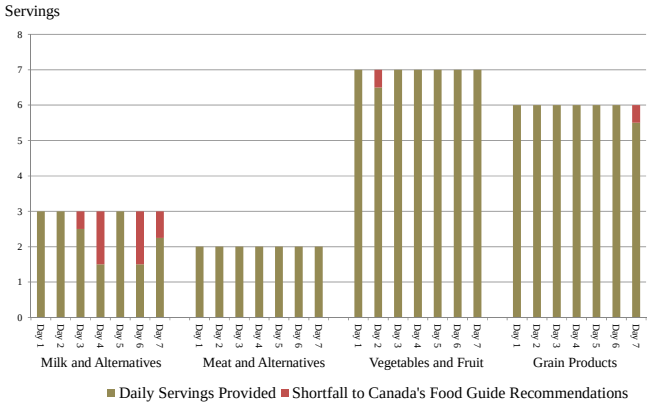
Figure 1

Nutrition in Long-term Care Facilities
Master Menus Compared to Canada's Food Guide Recommendations
One Week Cycle Deficiency Analysis

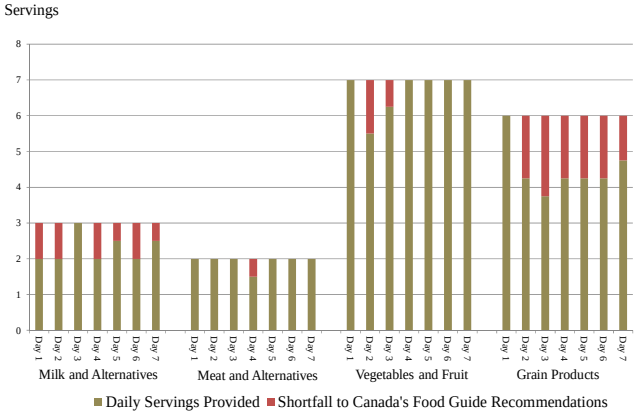
St. John's Long-term Care Facility



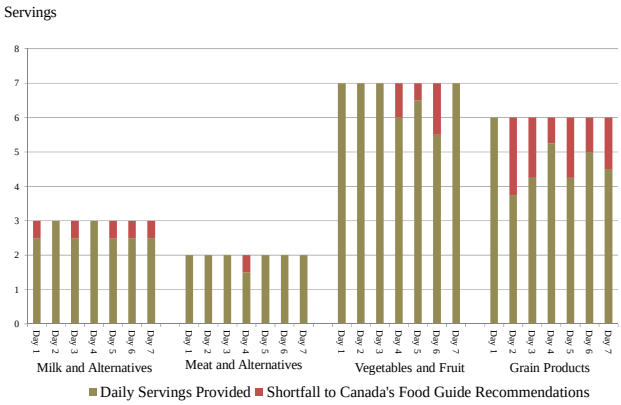
Dr. Albert O'Mahony Memorial Manor



Bay St. George Long-term Care Centre



Corner Brook Long-term Care Home



Master menus were not established in accordance with Canada's Food Guide, and as a result, residents were not always getting the recommended daily food servings for each of the four food groups.

As Figure 1 indicates, although the facilities' daily menus met Canada's Food Guide for some days for a particular food group, only the Dr. Albert O'Mahony Memorial Manor's master menu provided the recommended daily servings for all four food groups for two of the seven days. Also, as Figure 1 highlights, some of the deficiencies in the daily servings for certain food groups were significant compared to the recommended daily servings.

The four long-term care facilities master menus that were analyzed did meet the other recommendations from the Canada's Food Guide, except that the St. John's Long-term Care facility and Dr. Albert O'Mahony Memorial Manor did not provide the recommended two servings of fluid milk each day for vitamin D.

For the five long-term care facilities examined, the master menus did not always provide sufficient detail of the meals provided or did not always record what was actually being served to residents. For example:

- The Bay St. George Long-term Care Centre's, Dr. Albert O'Mahony Memorial Manor's and Glenbrook Lodge's master menus did not provide portion serving sizes for all fluids and meals in accordance with the Dietitians of Canada Best Practices.

- The Bay St. George Long-term Care Centre's master menu did not indicate alternative menu items as required by the Standards but provided alternative meals if requested.

- The Bay St. George Long-term Care Centre's and Glenbrook Lodge's master menus did not identify all therapeutic meal requirements such as healthy heart, diabetic or high fiber menus and/or texture modification menus as required under the Standards.

- The St. John's Long-term Care facility's master menu had items listed on the menu but it was not a standard item provided to residents and only provided to residents upon request. For example, whole wheat bread was on the master menu for breakfast but only served upon request, and milk and juice was on the master menu for lunch and supper but only served upon request.

- Glenbrook Lodge's menu included grapefruit juice to be served two or three times per week which was not allowed as per policy because of medication interactions. However, upon enquiry, staff indicated that grapefruit juice was not provided to residents.

Findings

15. For two long-term care facilities we reviewed, master menus were not always reviewed and revised annually by a registered dietitian as required.

16. For four long-term care facilities we reviewed, master menus did not provide residents with the recommended daily food servings for each of the four food groups established by Canada's Food Guide.

17. Insufficient information was available to perform an analysis on the master menu of the Glenbrook Lodge.

18. For four long-term care facilities we reviewed, the master menus did not always provide sufficient detail of the meals provided or did not always record what was actually being served to residents.

Individual Meal Plans

The nutritional assessment and reassessments of a resident may identify medical issues, food allergies, swallowing concerns, or resident preferences which require an individual meal plan to be developed. Individual meal plans may include regular meals which are texture modified such as pureed, minced, and diced due to swallowing concerns or other physical restrictions while other residents may have menus designed for diets such as healthy heart, diabetic or increased fibre. In addition, residents can also receive fluids that are texture modified.

For the five long-term care facilities examined, individual resident meal plans were updated either through a manual tracking method or an electronic dietary management database. Our review identified that all five facilities examined had different processes in place to track and monitor residents' dietary changes. Specifically:

- None of the five facilities had a system in place to assess whether an individual meal plan was in accordance with Canada's Food Guide.

- The Standards states that in order for a resident to receive clinical nutrition intervention consistent with their nutritional needs, a resident's dietary needs, which are based on a nutritional assessment and preferences, are included in the resident care plan and that clinical nutrition services are to be provided by a registered dietitian. Based upon this standard, texture and other major diet changes (excluding preferences) should be reviewed and approved by a registered dietitian to ensure these changes are consistent with the residents' care plan. The three facilities at Eastern RHA that we examined did not require a registered dietitian to review and approve diet changes requested by nursing staff. In addition, although the two facilities at Western RHA required the approval of a registered dietitian for diet changes made by nursing staff, our review identified that changes were not always approved by a registered dietitian.

- The Bay St. George Long-term Care Centre and Glenbrook Lodge requested diet changes using a manual requisition form while the other three facilities completed electronic requests through the Meditech system. This documentation was not always signed or initialed by the food services supervisor or dietary clerk to indicate that the request was processed to change a resident's meal plan as required.

- The Bay St. George Long-term Care Centre and Glenbrook Lodge indicated that during our review period they permitted verbal requests, therefore, documentation was not maintained on who made the request, what the dietary change was and when it was requested/actioned.

- The Bay St. George Long-term Care Centre and Glenbrook Lodge which used a manual resident meal plan tracking process did not provide meal tickets on the residents' food trays. The meal ticket records all items for a particular meal that is supposed to be served to a resident by nursing staff based on their dietary assessments. As a result, nursing staff could not verify the accuracy of the meal being served other than the texture and allergy restrictions.

Finding

19. The RHAs reviewed did not have consistent processes and systems in place to ensure resident meal plans were provided in accordance with Canada's Food Guide, that dietary changes were tracked, that texture and other major diet changes (excluding preferences) made by nursing staff were reviewed and approved by a registered dietitian, and that meal tickets were provided with the meal to ensure meals were provided in accordance to the resident's dietary profile.

3. Provision of Safe and Nourishing Meals

Objective

To determine whether RHAs provide safe and nourishing meals to residents.

Conclusion

For the five long-term care facilities we examined, the two RHAs generally provided safe and nourishing meals to residents, however, we identified issues with food safety, the provision of meals to residents, and the supervision of residents while eating.

Our review considered whether:

- RHAs operated safe and clean kitchen facilities;
- Food service providers followed hygienic work practices;
- Meals, including snacks and fluids, were provided in accordance with meal plans;
- Processes were in place to ensure meals were served at the appropriate temperature and texture; and
- Residents were assisted with their meals, if required.

3A. Provision of a Safe and Clean Environment

Introduction

The Standards require that correct sanitation and food handling procedures are implemented by staff and that these procedures are monitored and evaluated. In addition, the Standards require that the refrigeration and storage of food is in compliance with the appropriate Department of Health and Community Services regulations. In order to meet these Standards, we would expect clean and safe kitchen facilities, hygienic food handling practices, trained certified staff, proper storage processes and the regular inspection of facilities and processes.

Kitchen Facilities

All dietary employees must ensure that all steps in food production: thawing, food preparation, cooking, holding and storing are safe and efficient. RHAs are required to prepare food in a safe manner that adheres to the Hazardous Analysis Critical Control Point (HACCP) guidelines as outlined in the Food Safety Code of Practice for Canada's food service industry and the *Food Premises Regulations.*

During our site visits to five facilities we observed that kitchen facilities and dining areas appeared to be clean. In addition, the facilities:

- were regularly inspected by Service NL food premises inspectors and issues identified were resolved in the required timely manner;
- were regularly inspected by pest control contractors and no recent issues were identified;
- were regularly inspected by in-house occupational health and safety employees and issues were resolved in a timely manner;
- posted their food premise license;
- hired cooks with certification trade papers;
- were prepared for emergency events such as power failures, snow storms and labour unrest by having back-up generators, modified menus, dedicated suppliers, and assigned essential workers;
- were tested for drinking water safety by municipal inspectors and no recent issues were found; and
- were not providing wild meat as a menu item due to the high risk of food safety.

However, our review identified a number of weaknesses and inconsistencies in practices at the five long-term care facilities visited regarding kitchen and food safety as follows:

Food Safety Training

- Western RHA offered an annual food safety and sanitation in-service to its food services workers, although staff were not required to attend these sessions. As of December 2014:

    - 29% of employees at the Corner Brook Long-term Care Home did not attend the 2014 annual sessions; and
    - None of the employees at the Bay St. George Long-term Care Centre attended the 2014 annual sessions.

- Eastern RHA required a refresher course on food safety but not all employees were trained as of December 2014 in accordance with their policy:

    - The Dr. Albert O'Mahony Memorial Manor required annual training, however, 12% of employees were not trained;
    - The St. John's Long-term Care facility required training every three years, however, 74% of full-time staff were not trained and none of the temporary call-in food service workers were trained; and
    - The Glenbrook Lodge required training every five years, however, 45% of employees were not trained.

Food Temperature

- Depending upon the long-term care facility, temperature audits were required to be conducted on high risk foods, such as milk, upon delivery. We noted that:

    - The Bay St. George Long-term Care Centre, Corner Brook Long-term Care Home, and Glenbrook Lodge did not perform temperature audits as per the Food Safety Code of Practice which these facilities follow, except for ensuring frozen foods were frozen.

    - The Dr. Albert O'Mahony Memorial Manor did not perform temperature audits in accordance with their policy.

    - The St. John's Long-term Care facility performed temperature audits in accordance with their policy.

- The Bay St. George Long-term Care Centre, Corner Brook Long-term Care Home, Glenbrook Lodge and St. John's Long-term Care facility did not track the temperature in all refrigerators and freezers on a daily basis to ensure refrigerated foods were at the required temperature as required by the Standards.

- The Bay St. George Long-term Care Centre and Glenbrook Lodge did not record the temperature of each meal to ensure foods were cooked at appropriate temperatures as per the *Food Premises Regulations* under the *Food and Drug Act*.

Maintenance and Cleaning Schedules

- The Glenbrook Lodge, St. John's Long-term Care facility and Corner Brook Long-term Care Home did not have a preventive maintenance schedule in place for all their major kitchen equipment as required by the Standards.

- The Bay St. George Long-term Care Centre, Glenbrook Lodge, Dr. Albert O'Mahony Memorial Manor and St. John's Long-term Care facility did not have a cleaning schedule checklist for food services staff responsible for cleaning and sanitizing equipment and work areas. We would expect a checklist to be completed by a food service worker, and approved by a food service supervisor to ensure each task was done on a regular basis, as was done at the Corner Brook Long-term Care Home.

Food Storage

- The *Food Premises Regulations* under the *Food and Drug Act* states that cleaning materials should be stored in a compartment separate from food as to prevent the contamination of food. Bay St. George Long-term Care Centre and Glenbrook Lodge stored cleaning chemicals and cases of dietary supplements in close proximity in a receiving area room.

- The Bay St. George Long-term Care Centre, Glenbrook Lodge, and Dr. Albert O'Mahony Memorial Manor had food items stored on the floor instead of six inches off the floor to allow for proper air flow and proper cleaning. Only the Dr. Albert O'Mahony Memorial Manor required this as per their policy.

- The Dr. Albert O'Mahony Memorial Manor had their main dry stock pantry room located outside the kitchen area which was not locked and accessible to the public which was a violation of their policy.

Food Preparation

- The Glenbrook Lodge's kitchen staff used the same cutting board for raw meats, fruits and vegetables instead of using separate cutting boards which was identified in Service NL inspection reports.

- During our site visit at the Glenbrook Lodge, we identified food safety concerns such as food thawing schedules not being documented, thawing and prepared food items stored in refrigerators not properly labelled and cereal bags in storage not being sealed after use.

Finding

20. For the five long-term care facilities we examined, kitchen and dining areas were observed to be clean and regular inspections were performed, however, our facility visits identified food safety issues related to food safety training, food temperatures, maintenance and cleaning schedules, food storage and food preparation.

Food Service Hygienic Practices

During our facility visits, we observed that the five facilities had hygienic practices posted in the kitchen and food service workers were in compliance with their respective facilities' food services policies. For example, all staff wore hair nets and proper uniforms and food services staff did not wear jewelry**.** In addition, all facilities performed regular hand hygiene audits for nursing staff.

However, we found the following issues:

- None of the facilities had all their dietary employees trained in hand hygiene practices in accordance with their RHA policy as of our request on December 16, 2014.

- The Bay St. George Long-term Care Centre, Corner Brook Long-term Care Home, and Glenbrook Lodge did not perform hand hygiene audits for food service workers in the kitchen as they did for nursing staff to ensure workers were in compliance with good hygienic practices.

Finding

21. For the five long-term care facilities examined, RHAs had hygienic practices in place but did not always perform hand hygiene training and audits in the kitchen to ensure the safety of food provided to residents.

3B. Provision of Meals

Introduction

Meals should be provided to residents based upon their nutritional assessments and established meal plans. Meals should be provided at the appropriate texture and temperature, and supervised by qualified nursing staff. We selected a sample of 55 residents at five long-term care facilities to determine if their meals were being provided in accordance with their meal plans, meals were provided at the appropriate texture and temperature, and residents were being supervised when required.

Meal Plans

During December 2014 and January 2015, we observed 52 residents eating one meal (three residents were unavailable at the time of our visit) and compared their meal to a meal tray ticket or meal plan. In addition, we examined whether processes were in place to monitor whether residents were eating their meals. We found the following issues:

- All facilities required nursing staff to either manually record on a daily resident flow sheet or electronically in the Meditech system, the percentage of a meal consumed by the resident. The information was used to track eating patterns and used by registered dietitians in their assessments. However, this process did not provide sufficient eating patterns for assessment by a registered dietitian as the percentage consumed was not broken out for supplements and fluids intake, therefore the percent of a meal consumed lacked the necessary detail for a proper assessment.

- Nursing staff at the five facilities we examined were sometimes recording food allergies on a resident care plan and diet orders, however, the food items were determined to be intolerances and not allergies. Food service workers indicated that this was confusing for them when ensuring a resident's meal was provided in accordance with the resident care plan.

- The St. John's Long-term Care facility was not providing meals to residents who were on a healthy heart diet in accordance with Eastern RHA's established diet standard which required whole wheat bread, bran and low fat products to be provided. In our sample, two of 15 residents' diets did not receive these meal items as it was not a practice to provide this to residents on the hearty heart diet unless specifically requested.

- Our review of 52 meal tray tickets or meal plans identified that 28 had an omission or addition to a resident's tray or their tray was inconsistent with their documented assessment, for example:

  Eastern RHA

  St. John's Long-term Care facility
  - One resident did not receive their required supplement;
  - One resident was not served soup as required on their meal ticket;
  - One resident had diabetes but this was not recorded on their meal plan; and
  - Two residents received a supplement which was not provided for in the resident meal plan. Upon further review, one resident had received the supplement for four months.

  Glenbrook Lodge
  - One resident was served a main dish not consistent with their documented preference. The same resident did not receive their required supplement. Upon further review, the resident had not received the supplement for two years;
  - One resident was not served a second soup for supper as per their meal plan; and
  - One resident received a supplement which was not provided for in the resident's meal plan. Upon further review, the resident had received the supplement for four months.

  Dr. Albert O'Mahony Memorial Manor
  - One resident was served a main dish not consistent with their documented preference; and
  - One resident was receiving regular meal portions but was supposed to receive larger portions. Upon further review this had been occurring for ten weeks at the time of our visit.

Western RHA

Corner Brook Long-term Care Home

- One resident was receiving half meal portions but was supposed to receive full portions. Upon further review this had been occurring for seven weeks at the time of our visit; and
- One resident was not served soup for supper as requested since February 11, 2014.

Bay St. George Long-term Care Centre

- One resident had an intolerance to seeds but this was not recorded on their meal plan;
- One resident had an intolerance to oranges but this was not recorded on their meal plan;
- The diet of two residents was supposed to have increased fibre but this was not recorded on their meal plans; and
- One resident was not to have sweet desserts and was on a decreased fat diet but this was not recorded on their meal plan.

Findings

22. The facilities we reviewed did not always have processes in place to ensure residents were being provided and consuming meals in accordance with their meal plans.

23. The St. John's Long-term Care facility did not provide meals to residents on a healthy heart diet in accordance with all the requirements of Eastern RHA's established diet standard.

24. For the sample of 52 residents, 28 were not always provided meals in accordance with their prescribed meal plans.

Texture and Temperature of Food

Texture of Food

Preparing and providing meals in the proper texture is important to ensure residents are able to consume meals without any choking hazard. Both RHAs had policies on texture standards to assist staff in preparing and providing meals to residents reviewed, however, we noted the following issues:

- The texture standards were inconsistent between the RHAs, for example, the number of texture classifications was different.

- Texture standards were not posted at nursing stations located in the three facilities visited at the Eastern RHA as was done at the Western RHA. Nursing staff need direct access to these standards in preparing snacks and providing meals to residents.

- Western RHA's policy was to not thicken hot beverages because hot beverages were not able to hold the correct fluid consistency for very long which increased the risk of choking. However, at the two facilities we visited, nursing staff were thickening hot beverages for residents. Eastern RHA's policy allowed the thickening of hot beverages.

Our observation of 52 residents eating their meals identified six occurrences at three facilities where food was not provided at the proper texture as indicated in the most recent assessment or was not consistent with texture standards as follows:

- For the 10 residents' meals observed at the Glenbrook Lodge, two residents were on a finely chopped diet but had two food items on their lunch tray that were not finely chopped such as round sliced carrots and lemon cake. The residents were being fed by nursing staff that should have been aware of their textured diet.

- For the 10 residents' meals observed at the Glenbrook Lodge, one resident was transferred from a hospital and was served breakfast prepared as a minced diet (diet served before being transferred to the hospital), however, the resident was placed on a pureed diet at the hospital. We noted that no update for the change in diet was received from the hospital until after the breakfast was served.

- For the 15 residents' meals observed at the St. John's Long-term Care facility, one resident was on a chopped diet in which the Dietitians of Canada Best Practices required all food items to be served separately but nursing staff feeding the resident had all the food mixed together. Meal items should be fed to residents separately so that a resident can better enjoy the meal. A review of the resident's care plan did not indicate a preference to have their meal served in this way.

- For the 15 residents' meals observed at the Corner Brook Long-term Care Home, two residents were on a pureed diet but all the items were blended together. Kitchen staff prepared all 30 residents on this diet in the same manner, even though the Western RHA texture policy required all meal items to be prepared and pureed separately.

Temperature of Food

The Dietitians of Canada Best Practices require that meals, including liquids, be provided at safe, comfortable and palatable temperatures by ensuring food temperatures are taken and recorded at the point of service and that appropriate equipment is used to transport meals. We found that each facility we reviewed had taken measures to provide meals at the appropriate temperature such as having established meal delivery schedules, using base plate heaters, heated plates, insulated plate covers, insulated bowls and mugs, and the use of serveries (kitchenette work stations located on floors). Our review identified the following:

- The St. John's Long-term Care facility and the Corner Brook Long-term Care Home used heat induction base plate heaters to heat individual bases that plates were placed on in order to maintain the temperature for food for approximately one hour. We found that the St. John's Long-term Care facility only had one base heater in operation due to insufficient electrical outlets in the kitchen and in order to meet schedules, food service workers were preheating bases. Staff indicated that, based upon the size of the facility, two base heaters were required. In addition, the facility only used enough bases to cover breakfast for half of their residents so breakfast was served on a plate with no base. These factors could result in temperatures not being maintained at the appropriate level.

- We identified that the St. John's Long-term Care facility had 16 lounges which were all designed with a kitchen/servery, however, only half of them were being used. Given the size of the facility and time schedule to deliver meals to certain floors/wings of the facility, nursing staff stated that up to 20 minute delays could exist from the established schedule.

- The Bay St. George Long-term Care Centre and Glenbrook Lodge did not record temperatures of both hot and cold food and beverages during tray preparation as required by Dietitians of Canada Best Practices.

Finding

25. Although RHAs had policies and procedures for providing meals at the appropriate texture and temperature, our review of five long-term facilities identified issues where meals were not always provided at the proper texture and at the correct temperature and processes were not always present to ensure the texture and temperatures of meals were in accordance with RHA policy.

Resident Supervision

The Dietitians of Canada Best Practices require that meals be provided with appropriate dining supervision and staff should be present during eating in order to provide assistance. The Standards require that a supervised, socially enjoyable dining atmosphere be available. Adequate supervision is necessary to provide a comfortable atmosphere for the resident while dining, to provide assistance and encouragement to residents with their eating, and to prevent any choking occurrences.

The Western RHA required supervision during mealtimes in all dining areas while residents were eating. Western RHA's policy required the monitoring to be conducted by direct care staff under the supervision of the registered nurse and that direct care staff be assigned to a dining area at a ratio of a minimum of one staff member to ten residents. The Eastern RHA did not have specific policies governing the supervision of residents during meals.

Our review of the five long-term care facilities identified that residents were not always supervised in accordance with the Standard or RHAs' policy as follows:

- During our site visit to the Bay St. George Long-term Care Centre, we observed eight residents eating in the dining room that had no nursing supervision as required per RHA policy.

- We identified that two of the 15 residents in our sample at the Corner Brook Long-term Care Home had their meal trays left in their rooms next to the resident beds waiting for nursing staff to feed them, and in one case it was 25 minutes before a nurse was available. Leaving meal trays in rooms for residents requiring assistance not only results in delays in food being eaten, but could result in injury to the resident if they tried to feed themselves (i.e. choking).

- Although all facilities had designated dining areas which were generally used, we found the Bay St. George Long-term Care Centre did not use the designated dining areas to their fullest capacity. We noted that the dining room had a capacity of 28 for the 114 residents and while there was a large group living area that was suitable for dining, it was only used once each year for Christmas supper. We observed that many of the facility's residents were provided meals in small lounges within five feet of resident rooms that appeared crowded and were not conducive to an enjoyable dining atmosphere as required by the Standards. In addition, given the limited space available in the lounges, residents were not always situated for optimum supervision. For example, one resident we observed, who was determined to be a high risk of choking, was eating their meal without being in direct sight of direct care staff. The resident was not directly in the lounge but placed in the hallway near the lounge because there was no room left in the lounge to accommodate the resident.

- The Glenbrook Lodge had no requirement to have nursing staff in the dining room to supervise up to 25 residents during lunch and supper. In addition to being a supervision issue, there was no record of the percentage of food intake for each resident that would be normally recorded by nursing staff.

- The Corner Brook Long-term Care Home, Dr. Albert O'Mahony Memorial Manor, Glenbrook Lodge and St. John's Long-term Care facility indicated that they had issues with the timeliness of breakfast being served due to the morning shift change in nursing staff. The Bay St. George Long-term Care Centre was the only site that did not have an issue with the timeliness of breakfast being served to residents as shift changes were at 7:30 am, instead of 8:00 am.

- For the five long-term care facilities, we examined the training of all nursing staff that were feeding/serving meals to residents to determine if they were trained annually in foreign body obstruction related to choking. The Western RHA required all nursing staff to be trained annually, however, the Eastern RHA did not require nursing staff to be trained annually. We found that as at December 31, 2014, all registered nurses at the five facilities that we reviewed had been trained annually but licensed practical nurses and personal care attendants, the staff that typically feed residents were not always trained. The following provides a summary of all nursing staff not trained:

Eastern RHA

- 79% (400 of 506) of nursing staff at the St. John's Long-term Care facility were not trained;
- 72% (81 of 113) of nursing staff at the Glenbrook Lodge were not trained; and
- 62% (33 of 53) of nursing staff at the Dr. Albert O'Mahony Memorial Manor were not trained.

Western RHA

- 46% (90 of 194) of nursing staff at the Corner Brook Long-term Care Home were not trained; and
- 23% (25 of 111) of nursing staff at the Bay St. George Long-term Care Centre were not trained.

Findings

26. For the long-term care facilities examined, residents were not always supervised while eating in accordance with the Standards or RHA policy or a supervision policy was not documented.

27. For the long-term care facilities examined, nursing staff responsible for supervising residents while eating did not always receive annual training in foreign body obstruction.

4. Monitoring of Nutritional Services

Objective

To determine whether the Department and RHAs monitor and report on food services provided to residents of long-term care facilities.

Conclusion

The Department and RHAs had processes in place to monitor and report on food services provided to residents of long-term care facilities. However, for the RHAs and long-term care facilities in our sample, issues were identified in the RHAs' quality improvement processes related to process audits, complaints reporting and occurrence reporting. In addition, the Department and RHAs did not establish performance indicator benchmarks.

Our review considered whether:

- The planning and delivery of food services were periodically reviewed as part of an RHA's continuous quality improvement plan;
- Complaints and occurrences were documented, reviewed and timely corrective action was taken; and
- The Department and RHAs periodically monitored financial and statistical data, and variances were identified against established performance indicators, and explanations were provided.

Overview

The *Regional Health Authorities Act* states that an RHA is responsible for the delivery and administration of health and community services in its health region. In carrying out its responsibilities, an RHA shall monitor and evaluate the delivery of health and community services and compliance with the Standards and provincial objectives and in accordance with guidelines that the Minister may establish for the RHAs.

4A. Continuous Quality Improvement

Introduction

A key performance measure included in the Standards requires each standard, including those related to food and nutrition services, to be monitored and evaluated as part of an RHA's continuous quality improvement plan. Department officials indicated that RHAs are responsible for developing and implementing these quality improvement plans. A review of the Eastern and Western RHAs' quality improvement processes identified various policies, procedures and initiatives to monitor, evaluate and improve the quality of food and nutrition services, including satisfaction surveys, audits/inspections, resident family council meetings, occurrence reporting, complaint reporting, performance indicator reporting, annual reviews of plans, accreditation updates, and established review dates of policies and procedures.

Audits

Although, the Standards did not specifically require audits to be performed as part of a RHAs' continuous quality improvement, the five long-term care facilities that we examined conducted audits related to food and nutrition services. However, in the absence of direction from the Department, the two RHAs established different requirements for audits which resulted in audits being conducted inconsistently as follows:

- Preparation/production waste audits are to be conducted on a regular basis to determine the amount of food not used. This would assist food services staff in identifying and reducing wastage and incurring unnecessary food expense. The St. John's Long-term Care facility and Dr. Albert O'Mahony Memorial Manor, which both had contracted food services, performed these audits. Although not required, we found that the other three long-term care facilities did not conduct preparation/production waste audits.

- Resident meal wastage audits are to be conducted on a regular basis as required by Dietitians of Canada Best Practices to determine if a resident is eating adequately and if the menu items are suitable for the majority of the residents. The results also assist the dietitian in assessing the residents' food intake and helps reduce food wastage and cost. The St. John's Long-term Care facility, Dr. Albert O'Mahony Memorial Manor, Glenbrook Lodge and Bay St. George Long-term Care Centre had not completed a resident meal wastage audit. We noted that the Corner Brook Long-term Care Home completed three audits in 2013 and one audit in 2014 but it was only on specific menu items.

- Food service safety audits are to be conducted to ensure safe food practices are in place to protect residents from sickness or death. We found that the St. John's Long-term Care facility, Dr. Albert O'Mahony Memorial Manor and the Corner Brook Long-term Care Home were performing audits monthly as required by their food services policies. Although not required, we found that the other two long-term care facilities did not conduct food service safety audits.

- Clinical dietitian documentation audits are to be conducted to ensure dietitians are meeting the RHAs' policies and the Standards of Practice for Dietitians regarding residents' safety and quality of care. Our review identified that:

    - Eastern RHA required clinical dietitian documentation audits to be completed every two years. All audits in 2014 were performed as required.

    - Western RHA did not require clinical dietitian documentation audits to be completed.

Finding

28. The Standards did not specifically require audits to be performed as part of a RHAs' continuous quality improvement, and without direction from the Department, the two RHAs established different requirements for audits which resulted in audits being conducted inconsistently.

4B. Complaints and Occurrences

Introduction

A key monitoring tool used by the Department and RHAs is the recording and monitoring of complaints. RHAs also record and monitor occurrences. Complaints are usually filed by a resident, family member or citizen while occurrences are reported by RHA employees. The RHAs are required to have documented policies and procedures that provide for the proper identification, reporting and follow up of complaints and occurrences in accordance with the Standards.

Complaints

The Department has a complaints monitoring process that tracks complaints received, however, the Department indicated they did not receive any complaints regarding food services during the period April 2013 to December 2014.

Both of the RHAs we examined had complaints policies in place in accordance with the Standards. Four of five long-term care facilities we examined stated that no complaints had been received during the period April 2013 to December 2014. The St. John's Long-term Care facility had some complaints maintained in a file that staff indicated were either received verbally or through emails but no official complaint form was completed or tracked as per policy. Therefore, we could not determine whether the St. John's Long-term Care facility was complying with this policy.

Finding

29. Only the St. John's Long-term Care facility reported receiving complaints, however, Eastern RHA staff indicated that complaints were either reported verbally or through emails, but an official complaint form was not completed or tracked as required. As a result, we could not determine the true extent of complaints and whether the facility was responding to these complaints in accordance with RHA policy.

Occurrences Reporting

The Clinical Safety Reporting System (CSRS) is a tool used by all RHAs to manage occurrences. Each RHA had a policy designed to ensure residents received timely and appropriate follow-up care, and each occurrence was investigated in an organized, effective and timely manner. In addition, the quality and risk management office was to monitor, track and trend occurrences to identify opportunities for quality and safety improvements and shared learning. Table 4 provides a summary of occurrences reported for each of the five long-term care facilities examined.

Table 4

Nutrition in Long-term Care Facilities
Occurrence Reporting - Dietary Occurrences by Facility
For the Period April 1, 2013 to December 31, 2014

Type of Occurrence Reported	Eastern RHA			Western RHA		
	St. John's Long-term Care	Glenbrook Lodge	Dr. Albert O'Mahony Memorial Manor	Corner Brook Long-term Care Home	Bay St. George Long-term Care Centre	Total
Wrong diet or supplement	38	52	15	115	22	242
Choking hazard	30	15	4	27	11	87
Other	16	13	-	3	4	36
Ingestion of non-edible item	13	2	2	3	3	23
Foreign object found in food/on tray	1	4	-	8	3	16
Food allergy provided/not identified	2	3	-	6	4	15
Missed feeding/incorrect schedule	1	11	-	1	-	13
Total Occurrences Reported	**101**	**100**	**21**	**163**	**47**	**432**

Source: Regional Health Authorities' Clinical Safety Reporting System

The RHAs policies required that the individual reporting an occurrence complete an occurrence report within 24 hours of the occurrence being discovered. Western RHA's policy required the manager/approver to initiate a review process within 72 hours (excluding weekends and statutory holidays) after receiving the occurrence report. The manager/approver must have their investigation finished within six days after the manager began their review. Eastern RHA's policy required the manager/approver to initiate a review process within two days (excluding weekends and statutory holidays) after receiving the occurrence report. The manager/approver must have their investigation finished within seven days after the manager began their review. Therefore the manager/approver has a maximum of nine days in which an investigation of the occurrence should be completed for either RHA.

We examined five occurrences each at the three facilities we examined at the Eastern RHA and found that the occurrence reporting process was not completed in a timely manner for 11 of the 15 occurrences as follows:

St. John's Long-term Care facility
- managers initiated a review one day late in one occurrence; and
- managers completed an investigation two to 13 days late for three occurrences.

Glenbrook Lodge
- manager initiated a review one to three days late in two occurrences.

Dr. Albert O'Mahony Memorial Manor
- managers initiated a review two to six days late for four occurrences; and
- managers completed an investigation five to 39 days late for two occurrences.

We examined five occurrences each at the two facilities we reviewed at the Western RHA and found that the occurrence reporting process was not completed in a timely manner for six of the 10 occurrences as follows:

Corner Brook Long-term Care Home
- one occurrence was reported one day late; and
- managers initiated a review three to seven days late for three occurrences.

Bay St. George Long-term Care Centre
- managers initiated a review seven to 11 days late for three occurrences; and
- managers completed an investigation 19 and 20 days late for two occurrences.

Finding

30. The long-term care facilities examined were not always addressing reported occurrences within the timeframes outlined in the RHAs' policy.

4C. Financial and Statistical Data

Introduction

The Province uses the standards for Management Information Systems (MIS Standards) as published by the Canadian Institute for Health Information (CIHI) for the collection and reporting of financial and statistical information from health organizations. The MIS Standards are used by the RHAs and the Department to collect, process, analyze and use data to provide standard comparable operational information to decision makers. RHAs submit financial and statistical data electronically through Teledata monthly to the Department.

The MIS Standards also provide various performance indicators covering financial, staffing, productivity, utilization and workload measurements. Performance indicators were established in order to better analyze and evaluate services provided, compare performance, and assist in decision making. Indicator reports for each discipline can be generated from the MIS database at a provincial level, a regional level or a site level.

Department Monitoring of Information

The Financial Services Division of the Department reviews quarterly financial updates provided by the RHAs. The reviews are performed on global budgets by major category (i.e. salaries, supplies, etc.). During the fiscal year ended March 31, 2015, the Department began a new process where financial indicator reports were reviewed semi-annually (June 30 and December 31) for major variances and questions were provided to RHAs for explanation. Prior to this, the Department did not formally review and assess indicator reports on a regular basis.

Our review of the Department's monitoring processes for financial and statistical information identified that the Department has not established benchmarks or variance thresholds for each performance indicator for the Province, for each RHA or for each long-term care facility. Without benchmarks or variance thresholds being established for each performance indicator, it is not possible for the Department or RHAs to compare actual results to expected results and determine which variances should be investigated.

Finding

31. The Department has not established benchmarks and variance thresholds for each performance indicator for the Province, for each RHA or for each long-term care facility. Without benchmarks or variance thresholds being established for each performance indicator, it is not possible for the Department or RHAs to compare actual results to expected results and determine which variances should be investigated.

RHA Monitoring of Information

The Eastern and Western RHAs monitored and reported on financial information for food services and nutrition services as part of their monthly financial reporting which compares actual to budgeted expenditures. In addition, the RHAs had access to the performance indicator reports which provided comparative information by facility or by RHA.

The Eastern RHA also prepared and reviewed a monthly utilization report which provided actual and budgeted monthly and year-to-date expenditures, FTEs, meal days and cost per meal day for each long-term care facility.

The Western RHA also reported various financial and statistical data and performance indicators with its monthly financial reports which were provided to managers for review for any variances.

Our review of the RHAs' monitoring processes for financial and statistical information identified that the RHAs did not establish benchmarks and variance thresholds to be used for comparing actual to expected results of all performance indicators related to food services and nutrition services that were reviewed.

Finding

32. The RHAs did not establish benchmarks and variance thresholds to be used for comparing actual to expected results of all performance indicators related to food services and nutrition services that were reviewed.

Recommendations

1. The Department should conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador as required.

2. The Eastern RHA and Western RHA should develop food and nutrition services policies and procedures consistent with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and consider working with the other RHAs and the Department to establish policies and procedures that are consistent across the Province.

3. The Eastern RHA and Western RHA should ensure resident assessments are completed as required in order to maintain a current dietary profile for each resident.

4. The Eastern RHA and Western RHA should ensure the nutritional contents of the master menus comply with Canada's Food Guide, and that master menus are regularly assessed by a registered dietitian.

5. The Eastern RHA and Western RHA should ensure a resident's meal plan is established in accordance with the resident's dietary assessment and that texture and other major diet changes (excluding preferences) are reviewed and approved by a registered dietitian as required by the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

6. The Eastern RHA and Western RHA should ensure food safety, food temperatures, food storage, food preparation and maintenance and cleaning schedules are monitored and in accordance with the *Food Premises Regulations*, the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and RHA policy.

7. The Eastern RHA and Western RHA should provide meals to residents in accordance with their prescribed meal plans and at the appropriate temperature.

8. The Eastern RHA and Western RHA should ensure residents are appropriately supervised during meals in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and applicable RHA policies.

9. The Eastern RHA and Western RHA should improve their quality improvement processes by ensuring that process audits, complaints reporting and occurrences reporting are conducted in accordance with applicable RHA policies and such policies are consistent across the Province.

10. The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data, including performance indicators, against these benchmarks and follow up significant variances.

Department Response

Recommendation #1

1. The Department should conduct a formal review of the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador as required.

While a formal comprehensive review of the Long Term Care (LTC) Operational Standards was not completed, the Department works closely with the regional health authorities (RHAs) to address policy or procedural concerns on a regular basis. The Department is planning to review and revise the Operational Standards and will work closely with the RHAs and other stakeholders to identify opportunities to strengthen the Standards.

Recommendation #10

10. The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data, including performance indicators, against these benchmarks and follow up significant variances.

The Department reviews quarterly financial updates provided by the RHAs on global budgets by major category and follow up on significant variances. The Department also reviews select financial/statistical indicators semi-annually for major variances and seeks clarification from the RHAs on these variances. The Department will work with the RHAs to establish benchmarks for these financial/statistical indicators and will follow up on significant variances.

Thank you for the opportunity to respond to this report. The Department will work closely with the RHAs to strengthen the LTC Operational Standards and monitoring activities to ensure we are meeting the needs of our long term care residents.

Eastern Regional Health Authority Response

Recommendation #2

2. The Eastern RHA and Western RHA should develop food and nutrition services policies and procedures consistent with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and consider working with the other RHAs and the Department to establish policies and procedures that are consistent across the Province.

Eastern Health, through its contract services and clinical nutrition services, has a number of food and nutrition policies consistent with the operational standards guiding nutrition planning and monitoring. Eastern Health acknowledges that site specific policies are not available for the Salvation Army Glenbrook Lodge and will work with the Long Term Care leadership team there to achieve same for all of Eastern Health.

Furthermore, Eastern Health supports partnership with the Department and other regional health authorities to develop policy and procedures consistent with the Operational Standards.

Recommendation #3

3. The Eastern RHA and Western RHA should ensure resident assessments are completed as required in order to maintain a current dietary profile for each resident.

Eastern Health recognizes that resident assessment is a critical component of care and will develop an action plan to improve compliance with resident care planning and updates, MDS assessments, reassessments, interdisciplinary team conferences and weight assessments.

Recommendation #4 and #5

4. The Eastern RHA and Western RHA should ensure the nutritional contents of the master menus comply with Canada's Food Guide, and that master menus are regularly assessed by a registered dietitian.

5. The Eastern RHA and Western RHA should ensure a resident's meal plan is established in accordance with the resident's dietary assessment and that texture and any other major diet changes (excluding preferences) are reviewed and approved by a registered dietitian as required by the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

Eastern Health acknowledges the importance of menu planning and menu assessment by a dietitian, and will commit to working with the food contract service companies and leadership of Glenbrook Lodge to improve compliance in this area. It is important to note that while a master menu can be developed and approved by a dietitian that changes are often made on a weekly basis in response to such factors as production capabilities (i.e. seasonal foods available, equipment malfunction etc.), special occasions, resident preferences and changes in service models.

To reduce confusion for residents and families, master menus are not posted at our sites but are "available upon request". As noted above, weekly or even daily changes may need to be made to the master menu in response to a production capabilities. As well, the complexity of the resident population and their varied dietary needs requires many variations to the master menu (i.e. food types offered, texture, fluid). Reflecting the nuances of each diet type on a master menu is difficult and can be confusing for residents and families to interpret. To decrease confusion and promote a home-like milieu, most Eastern Health sites post daily menus.

It is important to recognize that our Nursing Home sites provide long term residential care and thus becomes the resident's home. While as a health organization we recognize the importance of meeting the recommendations of Canada's Food Guide we balance this need with a resident centered care approach. Many of our seniors have eaten traditional Newfoundland foods throughout their lives and are not amiable to making changes to their eating habits late in life. Our menu planning goal is to achieve resident satisfaction, meet Canada's Food Guide recommendations and minimize food wastage. While our master menus do not always provide exact daily serving recommendations of Canada's Food Guide, items (such as milk, bread and fruit) are made available for snacks and at other times to residents to request if desired.

Section 4, standard 9 Clinical Nutrition Services states that the resident's dietary needs, based on a nutritional assessment and preferences, are included in his/her care plan (9.2) and that services are provided by registered dietitians, licensed by the profession's provincial regulatory body (9.3). Eastern Health asserts that it is fully compliant with both performance measures 9.2 and 9.3. The standard does not state that any dietary changes be approved by a clinical dietitian. Eastern Health uses diet requisition guidelines that allow for dietary changes to be made by other health professionals including physicians, nurses, speech language pathologists as well as clinical dietitians.

The report notes that the master menus often did not provide sufficient information and/or details of the meals provided. Eastern Health acknowledges the need to improve documentation of meals and food items served on its master menu and also notes that the menu assessment was completed on the master menu which did not incorporate all snacks and beverages that are available to residents through standard unit supply. We deliver a significant amount of supplies to the units for residents to consume (in a homelike setting) throughout the day and this is included in EH's total menu assessment. All foods consumed daily must be considered when assessing compliance to the total daily intake recommendations of Canada's Food Guide.

Recommendation #6 and #7

6. The Eastern RHA and Western RHA should ensure food safety, food temperatures, food storage, food preparation and maintenance and cleaning schedules are monitored and in accordance with the Food Premises Regulations, the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and RHA policy.

7. The Eastern RHA and Western RHA should provide meals to residents in accordance with their prescribed meal plans and at the appropriate temperature.

Eastern Health acknowledges the importance of providing safe and nourishing meals. Eastern Health is committed to reviewing the recommendations outlined in the report and developing an action plan to address deficiencies.

The St. John's Long Term Care Site has already commenced this work as noted below:

- *Implementing an annual Food Safety and Sanitation training to all employees which will also be included as part of Departmental orientation for new hires.*
- *Ordering monitoring equipment (fridge thermometers) for all dining areas and incorporating this audit into servery logs.*
- *Partnering with Infrastructure Support to develop and implement a preventative maintenance schedule for food service equipment.*
- *Developing and implementing cleaning schedules for all food service equipment and work areas.*

Recommendation #8

8. The Eastern RHA and Western RHA should ensure residents are appropriately supervised during meals in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and applicable RHA policies.

Eastern Health believes it provides a supervised, socially enjoyable dining experience for its residents as required by the standards. Nursing staff complete foreign body obstruction related to choking as part of their pre-employment training. Additionally, Eastern Health provides refresher training as needed to nursing staff. While there is no standalone policy related to supervision in dining areas during meals, the Assignment Record for Nursing – Long Term Care (307-RC-300) encompasses this responsibility.

Recommendation #9

9. The Eastern RHA and Western RHA should improve their quality improvement processes by ensuring that process audits, complaints reporting and occurrences reporting are conducted in accordance with applicable RHA policies and such policies are consistent across the Province.

Eastern Health is committed to responding to complaints in a timely manner. Managers in Long term Care have recently completed training in the organizations new electronic complaints reporting system. The goal is to improve reporting practices, track response times and to identify systemic trends for improvement.

Similarly we are committed to addressing reported occurrences within the timeframes outlined in policy. Eastern Health follows the timeframes outlined within the CSRS Provincial Dictionary which defines the timeframe for completion of a review at 18 days, however, occasionally extra time may be required to ensure that managers complete a comprehensive investigation as needed.

Recommendation #10

10. The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data, including performance indicators, against these benchmarks and follow up significant variances.

Eastern Health has a robust internal review and monitoring process related to the analysis of actual financial and statistical data. Utilization (performance indicator) reports are forwarded to all managers monthly for review and as a discussion point during scheduled monthly meetings. These reports are also available on a self-service portal in Cognos (Managers' Toolkit) which allows any manager to access any month's data (indicator information) for analysis and review. Issues identified (with data quality and/or general enquiries) are communicated with their respective Budget Analyst for follow up and investigation.

Eastern Health would welcome the opportunity to work with the Department and other Regional Health Authorities on developing a provincial benchmarking initiative.

Eastern Health welcomes the findings of the Auditor General and looks forward to working with the Department of Health and Community Services and the other Regional Heath Authorities to strengthen the Standards related to Nutrition Planning and Monitoring in Long Term Care Facilities, and developing strong practices and procedures to guide the staff of this Authority in meeting the needs of long term care residents.

Western Regional Health Authority Response

Western Health is appreciative of the Office of the Auditor General's (OAG) review of Nutritional Planning and Monitoring in Long Term Care facilities and recommendations to improve planning and monitoring of nutritional services. Western Health is committed to continue to work with the Department of Health and Community Services (DHCS) as well as the other Regional Health Authorities (RHAs) to provide the highest quality of life and care for residents within long term care and support consistency in practices across the province.

In response to the recommendations outlined in the OAG report, Western Health would like to provide the following comments in relation to recommendations 2 through 10.

Recommendation #2

2. The Eastern RHA and Western RHA should develop food and nutrition services policies and procedures consistent with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and consider working with the other RHAs and the Department to establish policies and procedures that are consistent across the Province.

Western Health has numerous policies and procedures in place to support nutritional planning and monitoring within long term care. Western Health will work with the DHCS and other RHA's to ensure compliance with the Operational Standards for Long Term Care and establish consistency in policies and procedures throughout the province.

Recommendation #3

3. The Eastern RHA and Western RHA should ensure resident assessments are completed as required in order to maintain a current dietary profile for each resident.

Western Health acknowledges there is opportunity to improve the assessment process to maintain a current dietary profile for each resident. Auditing processes will be established to ensure assessments are completed within required timelines. As well, work is currently underway to provide an electronic reminder when these assessments are due within current electronic systems such as Clinical Online Documentation.

Recommendation #4

4. The Eastern RHA and Western RHA should ensure the nutritional contents of the master menus comply with Canada's Food Guide, and that master menus are regularly assessed by a registered dietitian.

Master menus are developed and maintained by a Registered Dietitian. Meals are planned based on recommendations from Canada's Food Guide. Western Health is in the process of establishing a plan for analyzing all long term care menus in accordance with food group servings as outlined in Canada's Food Guide.

Recommendation #5

5. The Eastern RHA and Western RHA should ensure a resident's meal plan is established in accordance with the resident's dietary assessment and that texture and other major diet changes (excluding preferences) are reviewed and approved by a registered dietitian as required by the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador.

Standard 9 of the Operational Standards for Long Term Care states that "There is provision for clinical nutrition services". As required by the standards, clinical nutrition services within Western Health are provided by Registered Dietitians and the resident's dietary needs are based on a nutritional assessment and preferences are included in the residents' meal plan. The standard does not state that all dietary changes including all texture and/or other major diet changes require approval by a Registered Dietitian. Western Health policy indicates that a diet order change can be made by the physician, clinical dietitian, or nurse to ensure a timely response to changes in a residents' condition and ensure safety. Changes must be communicated to the Registered Dietitian for follow-up, if needed. Western Health will work with the DHCS and other RHA's to ensure consistency in practice.

Recommendation #6

6. The Eastern RHA and Western RHA should ensure food safety, food temperatures, food storage, food preparation and maintenance and cleaning schedules are monitored and in accordance with the Food Premises Regulations, the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and RHA policy.

Western Health ensures all new staff in nutrition services receive food services and infection control training upon hiring. While refresher training is offered on an annual basis, it is recognized that there are opportunities to support staff in ongoing education. Western Health is willing to work with the DHCS and the RHA's to establish consistency in educational training requirements across the province.

Western Health acknowledges that food temperatures are not audited upon receiving food deliveries. Purchases are made only through approved suppliers who deliver in vehicles under controlled temperatures. Western Health agrees that temperature auditing is important and will be implemented regionally.

Western Health does monitor food temperatures during meal assembly and corrective action is taken if temperatures are not within the desired range. Western Health will implement consistent auditing practices.

The temperatures of all main refrigerators and freezers are checked and recorded several times daily. Western Health agrees that temperature monitoring of all refrigerators and freezers is important and will implement this practice consistently.

Within Western Health all equipment requiring scheduled preventative maintenance should be included in the computerized asset management system (MP2). It is recognized that at the time of this review, all major kitchen equipment at the Corner Brook Long Term Care Home was not included within the MP2 system. All equipment at Corner Brook Long Term Care Home has since been reviewed and entered into the MP2 system to generate the scheduled review date.

The cleaning and sanitizing of equipment and work areas at Bay St. George Long Term Care Centre is well established and incorporated into the daily work routines of food services staff. A formalized regional checklist consistent with that currently in place at Corner Brook Long Term Care Home will be implemented.

Recommendation #7

7. The Eastern RHA and Western RHA should provide meals to residents in accordance with their prescribed meal plans and at the appropriate temperature.

Western Health acknowledges there were minor inconsistencies in meals from the prescribed meal plan. However, these inconsistencies posed no risk to the involved residents. Western Health will review current processes and communication mechanisms to ensure meals are consistent with prescribed meal plans.

As previously noted, Western Health will implement consistent auditing practices for monitoring and documenting temperatures.

Recommendation #8

8. The Eastern RHA and Western RHA should ensure residents are appropriately supervised during meals in accordance with the Operational Standards for Long Term Care Facilities in Newfoundland and Labrador and applicable RHA policies.

Western Health's policy has been revised since the time of this review to more clearly reflect the appropriate levels of supervision of residents.

Recommendation #9

9. The Eastern RHA and Western RHA should improve their quality improvement processes by ensuring that process audits, complaints reporting and occurrences reporting are conducted in accordance with applicable RHA policies and such policies are consistent across the Province.

Western Health acknowledges that regular auditing is a good practice and there are opportunities to enhance audits currently being conducted within Long Term Care Nutrition Services. Western Health is willing to work with the DHCS and other RHA's to develop standard auditing requirements to establish consistency across the province.

As previously noted, Western Health's Client Feedback: Compliments and Complaints Policy (6-04-60) outlines the process for addressing formal complaints. As noted in the OAG report there were no formal complaints received related to nutrition services during the period of the review.

Western Health's Occurrence Reporting policy (06-02-15) is in compliance with the mandatory elements outlined in the provincial policy. Western Health acknowledges there are opportunities to improve the timeliness for initiating review and completing investigation of occurrences. While a number of strategies have already been implemented, Western Health will continue to work with the leadership group to comply with the required timelines outlined in the organizational policy.

Recommendation #10

10. The Department and the RHAs should establish benchmarks for performance indicators, review and monitor actual financial and statistical data, including performance indicators, against these benchmarks and follow up significant variances.

Western Health provides complete and accurate financial and statistical data to the DHCS on a monthly basis. Western Health will work with the DHCS and other RHA's to establish benchmarks and variance thresholds for identified performance indicators to ensure effective financial monitoring.

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 Department of Health and Community Services, the other Regional Health Authorities, as well as residents and families to improve current processes and ultimately enhance the quality of nutritional care provided to residents in long term care.

PART 3.7

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

PERSONAL CARE HOME REGULATION

Summary

Introduction

The *Health and Community Services Act* (the *Act*) provides the Department of Health and Community Services (the Department) with the overall responsibility of regulating Personal Care Homes (the PCHs) in the Province. The Regional Health Authorities (the RHAs) are mandated by the Department to license and monitor PCHs for compliance with the *Act*, the *Personal Care Home Regulations (*the *Regulations)*, and any policies, standards and guidelines established by the Department.

In 2007, the Department established the Provincial Personal Care Home Program Operational Standards (the PCH Operating Standards) which governs how PCHs are to be operated. The PCH Operating Standards identify 30 standards, 154 performance measures and associated procedures which the PCHs and the RHAs must reference to ensure proper governance, resident care, resident services, resident rights, financial services and records management.

Service NL, through its Government Service Centres (the GSCs) is responsible for monitoring the physical conditions of PCHs in accordance with the PCH Operating Standards. The PCH Operating Standards require that GSCs carry out annual inspections of PCHs to determine whether the PCHs are complying with various health and safety legislation and standards.

Objective

The objective of our review was to determine whether each of the Department, the four RHAs and the GSCs were regulating PCHs in accordance with the *Regulations* and current operational standards.

Scope

Our review covered the period April 1, 2012 to March 31, 2014. We reviewed the following: PCH legislation; the PCH Operating Standards; RHA/GSC policies and procedures; RHA licensing, monitoring and reporting documentation; GSC environmental health, and fire and life safety inspection reports; and other documents contained in PCH files maintained at the RHAs and GSCs. We also conducted interviews with officials of the Department, RHAs and GSCs. The samples we selected for our review were determined non-statistically on a judgmental basis.

We completed our review February 2015.

Conclusions

The Department did not always regulate Personal Care Homes in accordance with the *Personal Care Home Regulations* and current operational standards.

For our sample of 30 Personal Cares Homes, the RHAs and the GSCs could not always demonstrate that they were regulating Personal Care Homes in accordance with the *Personal Care Home Regulations* and current operational standards.

Findings

Department Policies, Guidelines and Standards

Review of PCH Operating Standards and RHA Monitoring Methods

1. The Department did not complete a comprehensive review of the PCH Operating Standards and RHA monitoring methods every two years as required by the PCH Operating Standards established under the *Regulations.* There has been no comprehensive review of the PCH Operating Standards since 2007 and no review of RHA monitoring methods since 2009. As a result, the current PCH Operating Standards and monitoring methods may not reflect current issues faced by PCHs or ensure that they are being effectively regulated.

2. Approximately 68 (44%) of the 154 performance measures identified in the PCH Operating Standards are not clearly defined and require further clarification to ensure they are effective measures for determining whether the RHAs, GSCs and PCHs are complying with the associated standards.

3. The PCH Operating Standards do not require that PCHs have an emergency preparedness plan detailing evacuation, relocation and other procedures in the event of emergencies such as power outages, fires and bomb threats.

PCH Monitoring Framework - RHA Monitoring Methods

4. In 2009, the PCH Monitoring Framework was revised to reduce the level of quarterly monitoring by RHAs from 48 to 12 performance measures because PCHs were consistently meeting them. However, approximately half of the 36 performance measures cut were not clearly defined and as such, it would have been difficult for RHA staff to demonstrate whether PCHs were meeting these performance measures.

5. Two performance measures related to PCH governance and records management standards were not included with the 12 performance measures that should be monitored quarterly, as required by the PCH Operating Standards. We found that the Eastern RHA monitored one of these performance measures quarterly and the other not at all. The remaining RHAs did not monitor either of the two performance measures.

PCH Monitoring Framework - Performance Measures

6. The PCH Monitoring and Quality Frameworks do not provide RHAs with sufficient guidance when monitoring PCHs for compliance with the PCH Operating Standards. They do not clearly define all performance measures or the evidence that would be sufficient, appropriate and reliable for assessing whether the performance measures were met by PCHs. As a result, it was difficult for RHA staff to properly determine whether standards were being complied with.

PCH Monitoring Framework - RHA Reporting

7. There is no requirement in the PCH Monitoring Framework for the Department to provide the results of RHA monitoring to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Licensing and Monitoring of PCHs by Regional Health Authorities

Licensing of Personal Care Homes

8. We found that for all 30 PCHs we reviewed, the RHAs renewed PCH licenses within one to three years as required.

9. In 8 (16%) of the 50 license renewals we examined, the RHA issued the PCH a license even though critical deficiencies identified in the fire and life safety inspection reports, had not been corrected by the PCH.

10. In 21 (42%) of the 50 license renewals we examined, the fire and life safety inspection reports reviewed by the RHA were more than six months old and therefore may not have provided the RHA with sufficient assurance that PCHs were complying with the PCH Operating Standards at the time of license renewal.

    In 6 (29%) of the 21 cases where the fire and life safety inspection reports reviewed by the RHA were more than six months old, we found that the inspector carried out an inspection of the PCH within 90 days after the date the license was renewed by the RHA. In these 6 inspections, the inspector identified a total of 28 critical fire and life safety deficiencies which required immediate correction or correction within a short timeframe. In one PCH, the inspector identified 16 critical deficiencies five days after the PCH was relicensed by the RHA.

11. In 21 (42%) of the 50 license renewals we examined, the GSC did not carry out a fire and life safety inspection at least 60 days prior to the license renewal date, as required.

12. In 14 (28%) of the 50 license renewals we examined, the GSC did not carry out an environmental health inspection at least 60 days prior to the license renewal date, as required.

13. In none (0%) of the 50 license renewals we examined, did the environmental health inspector recommend whether the PCH should continue to be licensed, as required.

14. In 28 (56%) of the 50 license renewals we examined, the technical inspector responsible for fire and life safety inspections did not recommend whether the PCH should continue to be licensed, as required.

Monitoring of Personal Care Homes

15. RHAs announce when they will be visiting PCHs to carry out monitoring activities for the purpose of completing quarterly and annual monitoring reports. Since these monitoring visits do not contain an element of surprise, the monitoring reports might not be a good indicator as to whether PCHs were complying with the PCH Operating Standards continuously throughout the year.

16. RHAs carry out unannounced monitoring visits for purposes other than to complete quarterly and annual monitoring reports. Our review indicated that the results of these unannounced monitoring visits carried out by the Eastern, Central and Western RHAs were not adequately documented and we were unable to readily determine the number of unannounced visits carried out and whether performance measures were being assessed. The Labrador-Grenfell RHA indicated that unannounced monitoring visits were not normally documented in the PCH file.

17. The Central and Labrador-Grenfell RHAs had not completed all the required quarterly monitoring reports for the 30 PCHs that we reviewed. Of the monitoring reports that were completed at all four RHAs, in 73% of the instances where RHA staff concluded that the PCH had met each performance measure, there was inadequate or no evidence to support the conclusion drawn. As a result, the RHA could not demonstrate that the PCHs were complying with the PCH Operating Standards at the high rates which they reported to the Department.

18. PCH staff did not always meet the minimum hiring requirements specified in the PCH Operating Standards. For example, in five (17%) of the 30 PCHs we reviewed, the PCH staff did not meet one or more of the minimum hiring requirements in all eight consecutive quarterly visits.

19. There were instances where RHA staff concluded that PCHs were complying with minimum hiring requirements even though they found that the PCH did not have the required documentation on file. As such, the rate at which this performance measure was met was inflated.

20. The RHAs completed all of the required annual monitoring reports for the 30 PCHs that we reviewed. However, in 73% of the instances where RHA staff concluded that PCHs had met each performance measure, there was inadequate or no evidence to support the conclusion drawn. As a result, the RHAs could not demonstrate that the PCHs were complying with the PCH Operating Standards at the high rates which they reported to the Department.

21. The RHAs could not provide evidence that annual medication storage audits were performed by a pharmacist/nurse in 8 (13%) of the 60 audits required for the 30 PCHs we reviewed during the two year period ended March 31, 2014.

Complaints

22. The Western RHA did not have documented PCH complaints policies and procedures in place.

23. The Central and Labrador-Grenfell RHAs did not maintain a database of complaints received regarding PCHs and were unable to readily provide us with a listing of PCH complaints that they received during our review period.

24. One of 18 complaints received in connection with seven PCHs we reviewed under the Central RHA was related to serious fire and life safety issues at the home. We found that the complaint was not addressed in a timely manner by the Central RHA.

Resident Care Reassessments

25. Annual resident reassessments were not always completed as required. For example, 26 (13%) of 200 resident annual reassessments were not carried out in connection with 100 residents that we selected for review in 30 PCHs. Furthermore, when annual resident reassessments were completed, they were not always completed within a year of the prior reassessment as required. For example, 90 (45%) of 200 annual resident reassessments were not completed by RHAs within a year of the prior annual reassessment. The number of days that the annual reassessments were overdue averaged 55 days and ranged from a high of 256 days to a low of one day.

Government Service Centre Inspections of PCHs

Inspection Planning, Scheduling and Reporting

26. GSC inspections of PCHs were not being carried out using a risk based approach and did not always contain the element of surprise. As a result, the GSCs could not provide RHAs with sufficient assurance that PCHs were complying with the PCH Operating Standards on a consistent basis throughout the year.

27. Inspection reports used by inspectors to record the results of fire and life safety inspections and environmental health inspections were inadequate because the reports did not identify key inspection areas and did not reference the associated legislation or standards which would represent a threat to the life, health and safety of PCH residents and staff, if not complied with.

28. We reviewed a sample of 168 inspection reports completed by technical and environmental health inspectors and found that numerous reports were difficult to read (some were illegible) and it was not always clear whether deficiencies identified were serious or not.

Fire and Life Safety Inspections

29. Six of the 30 PCHs we reviewed did not receive one of the required annual fire and life safety inspections during the two year period ended March 31, 2014. These PCHs were under the Central RHA.

30. Two inspectors in the Western GSC did not have the required training to carry out fire and life safety inspections during the two year period ended March 31, 2014.

31. We were unable to determine whether 16 critical fire and life safety deficiencies identified by GSC inspectors in seven of the 30 PCHs we reviewed, had been corrected immediately or within a very short timeframe. Furthermore, in six PCHs, the same nine critical deficiencies were identified by a GSC inspector in the following annual inspection.

32. GSC inspectors did not always provide PCHs with a timeframe to correct non-critical fire and life safety deficiencies. Timeframes for correction were not provided for 31 (29%) of the 107 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed.

33. We were not always able to determine whether non-critical deficiencies identified during inspections were ever corrected by the PCHs. We could not determine whether 46 (43%) of the 107 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed, were ever corrected.

34. Inspection reports for the 30 PCHs that we reviewed did not always indicate whether PCHs were complying with specific fire and life safety requirements in the PCH Operating Standards. For example, in 42 (78%) of 54 fire and life safety inspection reports, the inspector did not indicate whether the PCH was using and properly maintaining fuel fired, propane and oxygen systems.

35. For the 30 PCHs examined, fire and life safety inspection reports were provided to RHAs by the GSCs as required. However, there is no requirement in the PCH Operating Standards for the results of fire and life safety inspections to be made available to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Environmental Health Inspections

36. All 30 PCHs that we reviewed had received an annual environmental health inspection as required by the PCH Operating Standards.

37. We were unable to determine whether two critical environmental health deficiencies identified by GSC inspectors in two of the 30 PCHs we reviewed, had been corrected immediately or were controlled.

38. GSC inspectors did not always provide PCHs with a timeframe to correct non-critical environmental health deficiencies. Timeframes for correction were not provided for 19 (24%) of the 79 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed.

39. We were not always able to determine whether non-critical deficiencies identified during inspections were ever corrected by the PCHs. We could not determine whether 59 (75%) of the 79 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed, were ever corrected.

40. For the 30 PCHs examined, environmental health inspection reports were provided to RHAs by the GSCs as required. However, there is no requirement in the PCH Operating Standards for the results of environmental health inspections to be made available to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Food Premises Inspections

41. Food premises located in PCHs were inspected in accordance with the frequency required by the Department. Furthermore, for the 167 food premises inspection reports we examined, in connection with the 30 PCHs that we reviewed, the majority of the inspection reports were completed in a complete and accurate manner.

42. The PCH Operating Standards do not require, and the GSCs do not forward the results of food premises inspections to the RHAs for licensing and monitoring purposes.

43. The results of food premises inspections of PCHs are not required to be provided to the public, even though the results of other food premises inspections, such as restaurants, are made available to the public.

Recommendations

1. The Department should complete a comprehensive review of the PCH Operating Standards and RHA monitoring methods, every two years as required.

2. The Department should consider reporting the results of RHA monitoring of PCHs to the public.

3. The Eastern, Central and Labrador-Grenfell RHAs should only license PCHs when they comply with the PCH Operating Standards.

4. The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with the PCH Operating Standards.

5. The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.

6. The Eastern, Central and Western RHAs should ensure that PCH staff meet the minimum hiring requirements as required.

7. The Western RHA should implement complaints policies and procedures to ensure complaints are resolved in a timely manner. The Central RHA should resolve all complaints in a timely manner.

8. The four RHAs should carry out resident care reassessments annually as required.

9. The GSCs should consider implementing a risk based approach to conducting inspections of PCHs.

10. The GSCs should revise inspection reports to identify key inspection areas including references to appropriate codes, standards and legislation.

11. The GSCs should carry out annual fire and life safety inspections of PCHs at least once per year as required.

12. The GSCs should ensure that technical inspectors are trained to carry out fire and life safety inspections of PCHs as required.

13. The GSCs should ensure that critical deficiencies identified in PCHs are corrected immediately or within the timeframe specified.

14. The GSCs should provide PCHs with timeframes to correct non-critical deficiencies identified during inspections and ensure that the deficiencies are corrected within the timeframes specified.

15. The GSCs should consider reporting the results of inspections of PCHs to the public.

16. The GSCs should conduct fire and life safety inspections and environmental health inspections at least 60 days prior to the license renewal date and recommend whether PCHs should continue to be licensed as required.

Objective and Scope

Objective

The objective of our review was to determine whether each of the Department of Health and Community Services (the Department), the four Regional Health Authorities (the RHAs) and the Government Service Centres (the GSCs) were regulating Personal Care Homes (PCHs) in accordance with the *Personal Care Home Regulations* (the *Regulations*) and current operational standards.

Certain criteria for this examination were developed based upon relevant legislation and are therefore considered generally accepted. Other criteria were developed specifically for this examination based on our related work and reviews of literature including reports of other legislative auditors. The criteria were accepted as suitable by the senior management of the Department, the four RHAs and Service NL, except for:

- "Personal Care Home performance (compliance/non-compliance with legislation and standards) is reported to the residents, families of residents and the public", which was not accepted as a suitable criteria by the Western RHA, the Labrador-Grenfell RHA and Service NL; and

- "There are procedures/policies in place to address instances of non-compliance identified during monitoring/inspection activity to ensure they are corrected in a timely manner and there are procedures/policies in place to ensure serious instances of non-compliance (immediate threats to health and safety) are corrected or controlled immediately", which was not accepted as a suitable criteria by the senior management of the Western RHA and the Labrador-Grenfell RHA.

However, we decided to use both of these criteria in our review because we consider them to represent good practices. Furthermore, these practices are included in the operational standards of other programs administered by Government and of other programs administered by various provincial governments in Canada. Comparing practices across other programs within Government and other programs in various provinces is an appropriate procedure for developing suitable criteria for this review.

Scope

Our review covered the period April 1, 2012 to March 31, 2014. We reviewed the following: PCH legislation; the Provincial Personal Care Home Program Operational Standards (the PCH Operating Standards); RHA/GSC policies and procedures; RHA licensing, monitoring and reporting documentation; GSC environmental health, and fire and life safety inspection reports; and other documents contained in PCH files maintained at the RHAs and GSCs. We also conducted interviews with officials of the Department, RHAs and GSCs. The samples we selected for our review were determined non-statistically on a judgmental basis.

We completed our review in February 2015.

Background

The *Health and Community Services Act* (the *Act*) provides the Department with the overall responsibility of regulating Personal Care Homes (PCHs) in the Province. PCHs are licensed, privately owned and operated, residential homes for seniors and other adults who need assistance with daily living. Individuals residing in PCHs do not require on-site health or nursing services, but may require the services of a visiting professional such as a doctor or nurse. A PCH may be licensed for five or more adults to a maximum of 100 beds.

The four RHAs are mandated by the Department to license and monitor PCHs for compliance with the *Act*, the *Regulations*, and the Provincial Personal Care Home Program Operational Standards (the PCH Operating Standards) established by the Department. PCHs may only be licensed by RHAs when they meet PCH operational standards established for:

- building design;
- environmental health;
- fire/life safety;
- resident care, services and rights; and
- financial services and record keeping.

Service NL through its GSCs is responsible for inspecting PCHs to ensure they meet building design, environmental health, and fire/life safety standards. The RHAs are responsible for monitoring PCHs to ensure they meet resident care, services and rights, and financial services and record keeping standards.

Table 1 shows the number of PCHs and beds that were licensed by RHAs and the number and percentage of beds that were occupied by residents as at March 31, 2014.

Table 1

Personal Care Homes
Summary of Licensed and Occupied Beds, by Regional Health Authority
As at March 31, 2014

RHA	Number Licensed		Beds Occupied	
	PCHs	Available Beds	Number	Percentage
Eastern Regional Health Authority	51	2,098	1,595	76%
Central Regional Health Authority	23	1,079	826	77%
Western Regional Health Authority	15	776	545	70%
Labrador-Grenfell Regional Health Authority	5	167	137	82%
Total	**94**	**4,120**	**3,103**	**75%**

Source: Department of Health and Community Services

The RHAs are also responsible for the assessment, placement and re-assessment of individuals in PCHs. This process includes determining whether approved individuals are eligible for a financial subsidy. Since 2011-12, RHAs have paid PCHs an average of $21.4 million annually in resident subsidies. As at March 31, 2014, 2,183 (70%) of the 3,103 beds occupied by residents were subsidized. The maximum subsidy at that time was $1,850 per person per month.

Detailed Observations

Regulation of Personal Care Homes

Objective

The objective of our review was to determine whether each of the Department, the four RHAs and the GSCs were regulating PCHs in accordance with the *Regulations* and current operational standards.

Conclusions

The Department did not always regulate Personal Care Homes in accordance with the *Personal Care Home Regulations* and current operational standards.

For our sample of 30 Personal Cares Homes, the RHAs and the GSCs could not always demonstrate that they were regulating Personal Care Homes in accordance with the *Personal Care Home Regulations* and current operational standards.

We identified findings in the following areas:

A. Department Policies, Guidelines and Standards
B. Licensing and Monitoring of PCHs by Regional Health Authorities
C. Government Service Centre Inspections of PCHs

1A. Department Policies, Guidelines and Standards

Overview

In 2007, the Department, in consultation with the RHAs and the former Department of Government Services, established the PCH Operating Standards under authority of the *Regulations*. The PCH Operating Standards govern how PCHs are to be operated and provide standards, measures and procedures which the PCHs, RHAs, GSCs and Department must adhere to. The PCH residents' right to be treated with dignity is fundamental to the elements of each standard and the performance measures used to assess compliance with each standard. The PCH Operating Standards identify 30 standards, 154 performance measures and associated procedures in five main areas:

1. governance;
2. licensing;
3. resident services and resident rights;
4. resident care; and
5. financial services and records management.

The Department developed a PCH Monitoring Framework for the Provincial Personal Care Home Program (the PCH Monitoring Framework) outlining monitoring methods which should be used by RHAs to determine whether PCHs were complying with the PCH Operating Standards. The Framework identifies the:

- resident care information (ie: number of falls, infections, incidents) that must be collected by the PCHs and reported to the RHAs each month;
- performance measures RHAs must assess to determine whether PCHs are complying with the PCH Operating Standards;
- standardized monitoring reports that RHAs must use to document evidence collected to support their assessment of whether performance measures were achieved;
- frequency by which RHAs must monitor PCHs in order to determine whether the PCHs are complying with the PCH Operating Standards; and
- format and frequency by which RHAs must report resident care information and PCH Operating Standard compliance information to the Department.

We reviewed the *Regulations*, the PCH Operating Standards and the PCH Monitoring Framework and held discussions with Department and RHA officials. Our review indicated the following:

Review of PCH Operating Standards and RHA Monitoring Methods

As resident care, program and service requirements change, the revision of existing standards, measures, procedures and monitoring methods may be necessary. The PCH Operating Standards specifically require that the Department complete a comprehensive review of the PCH Operating Standards, including RHA monitoring methods, every two years.

We found that the Department had not completed a comprehensive review of the PCH Operating Standards and RHA monitoring methods every two years as required. Specifically, there had been no comprehensive review of the PCH Operating Standards since 2007 and no review of RHA monitoring methods since 2009. Department officials indicated that while comprehensive reviews were not completed as required, there was a process whereby RHAs brought forward issues as they arose. These issues were reviewed by the Department and amendments were made to the PCH Operating Standards and RHA monitoring methods, as necessary. Department officials also indicated that a comprehensive review process was initiated in October 2013 and that a working group had been established to review the PCH Operating Standards. At the time of our review, most of the PCH Operating Standards had been reviewed and the existing PCH Operating Standards and PCH Monitoring Framework are expected to be revised.

We reviewed the current PCH Operating Standards and found that:

- Approximately 68 (44%) of the 154 performance measures identified in the PCH Operating Standards are not clearly defined and require further clarification to ensure they are effective measures for determining whether the RHAs, GSCs and PCHs are complying with the associated standards. For example, one of the performance measures used by RHAs to determine compliance with a financial services standard states that, *"The operator refers issues of concern regarding trust funds to the RHA"*. This statement appears to be more procedural in nature and is not measureable.

- There is no requirement that PCHs have an emergency preparedness plan detailing evacuation, relocation and other procedures in the event of emergencies such as power outages, fires and bomb threats.

Findings

1. The Department did not complete a comprehensive review of the PCH Operating Standards and RHA monitoring methods every two years as required by the PCH Operating Standards established under the *Regulations*. There has been no comprehensive review of the PCH Operating Standards since 2007 and no review of RHA monitoring methods since 2009. As a result, the current PCH Operating Standards and monitoring methods may not reflect current issues faced by PCHs or ensure that they are being effectively regulated.

2. Approximately 68 (44%) of the 154 performance measures identified in the PCH Operating Standards are not clearly defined and require further clarification to ensure they are effective measures for determining whether the RHAs, GSCs and PCHs are complying with the associated standards.

3. The PCH Operating Standards do not require that PCHs have an emergency preparedness plan detailing evacuation, relocation and other procedures in the event of emergencies such as power outages, fires and bomb threats.

PCH Monitoring Framework - RHA Monitoring Methods

In order to be effective, the monitoring of PCHs should follow a risk based approach. There should be an annual plan that identifies:

- the number of PCHs to be monitored;
- the life, health and safety risk associated with each PCH; and,
- the timing/frequency of monitoring required to reduce any identified risks.

PCHs identified as being a greater risk (ie: many residents, numerous complaints and poor monitoring history) should be monitored more frequently to ensure compliance with the PCH Operating Standards.

The PCH Operating Standards manual identifies 154 performance measures which the Department, RHAs, GSCs and PCHs must meet to ensure that the 30 standards specified in the manual are complied with. The PCH Monitoring Framework identifies 88 of the 154 performance measures that RHAs should assess when determining whether PCHs are complying with the PCH Operating Standards. In particular, the PCH Monitoring Framework requires that 12 of the 88 performance measures are to be assessed quarterly and the remaining 76 are to be assessed annually by RHA staff during monitoring visits. Most of the remaining 66 performance measures relate to specific Department, RHA, or GSC responsibilities under the PCH Operating Standards. The results of these visits are documented on a standardized monitoring report and RHA staff must conclude whether the PCHs are complying with the PCH Operating Standards.

Our review indicated the following:

- There is no formal risk management plan completed. The level of monitoring outlined in the PCH Monitoring Framework was developed through discussion with the RHAs and was considered sufficient by the Department for ensuring PCH compliance with the PCH Operating Standards. Department officials indicated that it determined which performance measures were to be assessed quarterly and which were to be assessed annually based on the importance of each operating standard and the potential risk related to resident safety or quality of care in the PCH.

  Prior to 2009, the Department determined that RHAs should assess 48 performance measures quarterly and 40 measures annually. In 2009, the PCH Monitoring Framework was revised and the quarterly requirement was reduced by 36, from 48 to 12, and the annual requirement increased by 36, from 40 to 76. This reduction in monitoring occurred when the RHAs found that PCHs were consistently meeting the 36 performance measures every quarter. However, we found that approximately half of these 36 performance measures were not clearly defined. As a result, it would have been difficult for RHA staff to demonstrate whether PCHs were meeting these performance measures. Thus, the Department may have reduced the quarterly monitoring for some performance measures when there was a risk that PCHs would not have met the measure had it been more clearly defined.

- The PCH Operating Standards specify two performance measures which require quarterly assessment by the RHAs, despite this, these measures were not included with the 12 performance measures identified in the PCH Monitoring Framework. One of the performance measures relates to a governance standard, which states that RHA staff are required to review complaints and incident reports at PCHs every quarter to ensure that complaints are addressed in a timely manner. We found that this performance measure was being monitored quarterly only by the Eastern RHA. The other performance measure relates to a records management standard, which states that RHA staff must monitor a sample of resident records at PCHs every quarter to ensure that resident information is up-to-date. We found this performance measure was not being monitored by the RHAs.

Findings

4. In 2009, the PCH Monitoring Framework was revised to reduce the level of quarterly monitoring by RHAs from 48 to 12 performance measures because PCHs were consistently meeting them. However, approximately half of the 36 performance measures cut were not clearly defined and as such, it would have been difficult for RHA staff to demonstrate whether PCHs were meeting these performance measures.

5. Two performance measures related to PCH governance and records management standards were not included with the 12 performance measures that should be monitored quarterly, as required by the PCH Operating Standards. We found that the Eastern RHA monitored one of these performance measures quarterly and the other not at all. The remaining RHAs did not monitor either of the two performance measures.

PCH Monitoring Framework - Performance Measures

To supplement the PCH Monitoring Framework, the Department led an RHA working group which developed a working document, the Quality Framework - Identification of Measures by Standard (the Quality Framework), to assist RHA staff with the completion of the standardized monitoring reports identified in the PCH Monitoring Framework. The Quality Framework identifies possible sources of evidence which could be obtained by RHAs for the purpose of determining whether each of the 88 performance measures included in the monitoring reports were being met.

Our review of the Quality Framework indicated that it does not provide RHA staff with sufficient guidance when monitoring PCHs for compliance with the PCH Operating Standards. A significant number of the performance measures and most of the sources of evidence used to assess whether PCHs are complying with the associated PCH Operating Standards are not clearly defined. For example, one of the 68 performance measures we identified earlier in our report as not being clearly defined is being used by RHAs to determine compliance with a governance standard. This performance measure states, "*There is a continuous quality improvement process in place in the home for identifying risk areas, collecting necessary data and following up as necessary. The process is reviewed on a regular basis and adjusted as necessary*". Possible sources of evidence that were identified in the Quality Framework when considering whether the PCH met this performance measure included:

- evidence of staff meeting;
- resident councils;
- suggestion boxes;
- audits;
- monthly standards reports; and
- satisfaction surveys.

We found that the Quality Framework does not define what would constitute a "*continuous quality improvement process*" and does not define which of the sources of evidence identified above (ie: any, all, or some combination of), would be sufficient and appropriate to determine whether there was a continuous quality improvement process in place at the PCH. Furthermore, the Quality Framework does not specify what is expected in ensuring that the "*process is reviewed on a regular basis*". As a result, there was insufficient guidance for RHA staff to properly determine whether this standard was being complied with. However, in all of the 60 monitoring reports that we examined, in connection with the 30 PCHs we reviewed, RHA staff concluded that the PCH had met this performance measure and in no instances did RHA staff document what procedures were performed to arrive at their conclusion. Furthermore, when RHA staff provided comments to support their conclusion, these comments were very brief and could not be linked to any clearly defined measure. We found comments such as "suggestion box" or "staff meetings". No information was provided as to what risk areas may have been identified from the "suggestion box" or whether these risk areas were addressed. No information was provided as to whether "staff meetings" were held as scheduled, whether there were minutes taken, and whether any risk areas identified in the minutes were addressed.

Finding

6. The PCH Monitoring and Quality Frameworks do not provide RHAs with sufficient guidance when monitoring PCHs for compliance with the PCH Operating Standards. They do not clearly define all performance measures or the evidence that would be sufficient, appropriate and reliable for assessing whether the performance measures were met by PCHs. As a result, it was difficult for RHA staff to properly determine whether standards were being complied with.

PCH Monitoring Framework - RHA Reporting

The PCH Monitoring Framework requires that RHAs report to the Department on whether PCHs are meeting 88 of 154 performance measures identified in the PCH Operating Standards. Department officials indicated that these reports are reviewed and that the Department has a close relationship with the RHAs and are aware of any significant non-compliance issues which may be ongoing in the PCHs. These reports are placed in an electronic file at the Department where staff can access the data if needed.

There is no requirement in the PCH Monitoring Framework for the Department to provide the results of the quarterly and/or annual RHA monitoring reviews to the public. However, such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Finding

7. There is no requirement in the PCH Monitoring Framework for the Department to provide the results of RHA monitoring to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

1B. Licensing and Monitoring of PCHs by Regional Health Authorities

Overview

The four RHAs are mandated by the Department to license and monitor PCHs for compliance with the *Regulations* and the PCH Operating Standards established by the Department. The PCH Operating Standards identify 154 performance measures and associated procedures related to the licensing and monitoring of PCHs.

The *Regulations* require that RHAs renew the licenses issued to PCHs every one to three years. A license may be renewed after the RHA determines that the PCH is complying with the PCH Operating Standards. Compliance is determined based on RHA reviews of the:

- quarterly and annual monitoring reports completed by RHA staff;
- fire and life safety and environmental health inspection reports completed by GSC inspectors; and
- liability insurance carried by the PCH.

RHAs are required to monitor PCHs on a quarterly basis to ensure that the PCHs are complying with the PCH Operating Standards. RHA staff must visit the PCHs and complete quarterly and annual monitoring reports indicating whether the PCHs meet performance measures specified by the Department in the PCH Monitoring Framework.

The GSCs carry out annual fire and life safety and environmental health inspections at PCHs to determine compliance with the legislation, codes and standards specified in the PCH Operating Standards. Inspection results are documented in an inspection report and forwarded to the RHAs. The inspection report must provide an annual recommendation with respect to whether the PCHs should continue to be licensed. RHAs are required to notify the GSC of their PCH licensing schedules so that the GSC may schedule and carry out inspections prior to the existing PCH license expiry date.

Table 2 shows the number of PCHs and license renewal frequency by RHA as at March 31, 2014.

Table 2

Personal Care Homes
Number of PCHs and License Renewal Frequency by RHA
As at March 31, 2014

RHA	Number of PCHs	PCH License Renewal Frequency
Eastern	51	Every year
Central	23	Every second year
Western	15	Every one to three years
Labrador-Grenfell	5	Every year
Total	**94**	

Source: Regional Health Authorities

As Table 2 shows, RHAs do not renew the licenses of PCHs at the same frequency.

We reviewed the PCH Operating Standards, the Monitoring and Quality Frameworks, RHA policies and procedures for PCHs, RHA monitoring reports and related documentation and GSC inspection reports and related documentation. We held discussions with Department, RHA and GSC officials. We identified issues in the following areas:

i. Licensing of Personal Care Homes
ii. Monitoring of Personal Care Homes
iii. Complaints
iv. Resident Care Reassessments

1B(i). Licensing of Personal Care Homes

Introduction

The PCH license renewal process is managed by PCH Coordinators in the Eastern, Central and Labrador-Grenfell RHAs and by a Manager in the Western RHA. They are responsible for obtaining and reviewing all documentation required for license renewal, including: RHA monitoring reports and related documentation; GSC inspection reports and related documentation; and proof of liability insurance. Licenses are approved by a Manager in the Eastern RHA and by a member of the executive in the Central, Western and Labrador-Grenfell RHAs. Licenses are issued to PCHs when there are no serious instances of non-compliance with the PCH Operating Standards. Serious instances of non-compliance with the PCH Operating Standards identified during the license renewal process must be corrected by the PCH before a license is approved for renewal. Serious instances of non-compliance include:

- Deficiencies that exist which may threaten the life, health and safety of residents and staff in the PCH. For example, if one or more of the fire detection, alarm, suppression and sprinkler systems are not operating or are not certified as operating.

- One or more deficiencies which, on their own, or together, negatively impact resident care and services in the PCH. For example, staff not properly trained or supervised, meal plans not always followed, residents not always receiving meals, resident and family complaints not addressed.

RHAs may provide PCHs with a temporary license or license extension while the RHA and PCH address the instances of non-compliance. Licenses are renewed only when the RHA obtains evidence that the PCH has taken the corrective action required.

Table 3 shows the frequency and number of PCH licenses renewed by RHAs for the PCHs that we reviewed during the two year period ended March 31, 2014.

Table 3

Personal Care Homes
Frequency and Number of PCH Licenses Renewed by RHAs for PCHs Reviewed
Two year period ended March 31, 2014

RHA Region	License Renewal Frequency	Number of PCHs Reviewed	Number of Licenses Renewed		Overall Total
			2012-13	2013-14	
Eastern	Every year	16	16	16	**32**
Central	Every second year	7	5	2	**7**
Western	Every one to three years	5	3	4	**7**
Labrador	Every year	2	2	2	**4**
Total		**30**	**26**	**24**	**50**

As Table 3 shows, for the 30 PCHs that we reviewed, RHAs renewed 50 PCH licenses throughout the Province during the two year period ended March 31, 2014.

Our review indicated the following:

License Renewal Frequency

We found that for the 30 PCHs we reviewed, the RHAs renewed PCH licenses within one to three years as required by the applicable RHA during the two year period ended March 31, 2014.

Finding

8. We found that for all 30 PCHs we reviewed, the RHAs renewed PCH licenses within one to three years as required.

PCH License Renewal and GSC Inspections

The PCH Operating Standards require that GSCs carry out annual fire and life safety and environmental health inspections of PCHs at least 60 days before the existing PCH license is scheduled to expire (license renewal date), and make a recommendation to the RHAs as to whether the PCHs should continue to be licensed.

Our review of 50 license renewals in connection with the 30 PCHs we reviewed during the two year period ended March 31, 2014, indicated that:

- In 8 (16%) of the 50 license renewals we examined, the RHA issued the PCH a license even though critical deficiencies identified in the fire and life safety inspection reports reviewed by the RHA, had not been corrected by the PCH.

- In 21 (42%) of the 50 license renewals we examined, the fire and life safety inspection reports reviewed by the RHA were more than six months old (dated between 180 and 376 days prior to license renewal date).

  In 6 (29%) of the 21 cases, we found that the inspector carried out an inspection of the PCH within 90 days after the date the license was renewed by the RHA. In these 6 inspections, the inspector identified a total of 28 critical fire and life safety deficiencies which required immediate correction or correction within a short timeframe. In one PCH, the inspector identified 16 critical deficiencies five days after the PCH was relicensed by the RHA. Examples of the critical deficiencies included: fire alarm, kitchen fire suppression and sprinkler systems all out of date; fire extinguishers out of date; fire extinguisher removed; and emergency lighting not working.

  Unless GSC inspections are carried out within a timeframe that is close to the license renewal date, the GSC may not be able to provide RHAs with sufficient assurance that PCHs are complying with the PCH Operating Standards at the time of license renewal.

- In 21 (42%) of the 50 license renewals we examined, the GSC did not carry out a fire and life safety inspection at least 60 days prior to the license renewal date, as required. In 14 (28%) of the 50 license renewals we examined, the GSC did not carry out an environmental health inspection at least 60 days prior to the license renewal date, as required. These 35 inspections were carried out within 60 days of the license renewal date and almost all occurred at PCHs under the Eastern RHA.

- In none (0%) of the 50 license renewals we examined, did the environmental health inspector recommend whether the PCH should continue to be licensed, as required. In 28 (56%) of the 50 license renewals we examined, the technical inspector responsible for fire and life safety inspections did not recommend whether the PCH should continue to be licensed, as required.

Findings

9. In 8 (16%) of the 50 license renewals we examined, the RHA issued the PCH a license even though critical deficiencies identified in the fire and life safety inspection reports, had not been corrected by the PCH.

10. In 21 (42%) of the 50 license renewals we examined, the fire and life safety inspection reports reviewed by the RHA were more than six months old and therefore may not have provided the RHA with sufficient assurance that PCHs were complying with the PCH Operating Standards at the time of license renewal.

    In 6 (29%) of the 21 cases where the fire and life safety inspection reports reviewed by the RHA were more than six months old, we found that the inspector carried out an inspection of the PCH within 90 days after the date the license was renewed by the RHA. In these 6 inspections, the inspector identified a total of 28 critical fire and life safety deficiencies which required immediate correction or correction within a short timeframe. In one PCH, the inspector identified 16 critical deficiencies five days after the PCH was relicensed by the RHA.

11. In 21 (42%) of the 50 license renewals we examined, the GSC did not carry out a fire and life safety inspection at least 60 days prior to the license renewal date, as required.

12. In 14 (28%) of the 50 license renewals we examined, the GSC did not carry out an environmental health inspection at least 60 days prior to the license renewal date, as required.

13. In none (0%) of the 50 license renewals we examined, did the environmental health inspector recommend whether the PCH should continue to be licensed, as required.

14. In 28 (56%) of the 50 license renewals we examined, the technical inspector responsible for fire and life safety inspections did not recommend whether the PCH should continue to be licensed, as required.

1B(ii). Monitoring of Personal Care Homes

Introduction

RHAs carry out quarterly and annual monitoring activities at PCHs in accordance with the Monitoring and Quality Frameworks. The PCH Monitoring Framework identifies 88 of the 154 performance measures in the PCH Operating Standards which the RHAs are required to monitor, provides standardized reports which RHAs must use to document the results of their monitoring activity and identifies the frequency and format by which the RHAs must report monitoring results to the Department.

RHA staff who carry out the monitoring activities may include any combination of the following:

- PCH Coordinator or Manager;
- Community Health Nurse (CHN);
- Social Worker (SW);
- Dietician; and/or
- Financial Assessment Officer (FAO).

Table 4 shows the average percentage of performance measures met by PCHs during the two year period ended March 31, 2014, as reported to the Department by the RHAs.

Table 4

Personal Care Homes
Average Percentage of Performance Measures Met by PCHs as Reported by RHAs
Two year period ended March 31, 2014

PCH Operating Standards Type	Number of Measures	Average Percentage of Performance Measures Met During Two Year Period Ended March 31, 2014				Overall Average (94 PCHs)
		ERHA (51 PCHs)	CRHA (23 PCHs)	WRHA (15 PCHs)	LGRHA (5 PCHs)	
1. Governance	8	99%	100%	91%	94%	96%
2. Licensing	9	96%	99%	95%	94%	96%
3. Resident Services & Rights	21	99%	99%	96%	97%	98%
4. Resident Care	35	95%	99%	93%	96%	96%
5. Financial & Records	15	91%	99%	93%	98%	95%
Total /Average	**88**	**96%**	**99%**	**94%**	**96%**	**96%**

Source: Department of Health and Community Services

As Table 4 shows, the RHAs reported that the 88 performance measures were met by PCHs at an average rate of 96% during the two year period ended March 31, 2014. Thus, PCHs were found to be complying with the PCH Operating Standards at a high rate.

Our review indicated the following:

Monitoring Frequency and Schedule

The PCH Operating Standards require RHAs to carry out monitoring visits at PCHs every quarter and complete quarterly and annual monitoring reports. Additional visits to the PCH for the purpose of determining compliance with the PCH Operating Standards may be made at the discretion of the RHA. We found the following:

- RHAs announce when they will be visiting PCHs to carry out monitoring activities for the purpose of completing quarterly and annual monitoring reports. Due to the absence of some element of surprise, areas of non-compliance with the PCH Operating Standards could be corrected prior to the visit. As a result, the monitoring reports might not be a good indicator as to whether PCHs were complying with the PCH Operating Standards continuously throughout the year.

- The Eastern RHA is the only RHA which requires that their staff carry out unannounced or surprise monitoring visits at PCHs. These visits are carried out quarterly by the CHN and SW, and annually by the Dietician. The Central, Western and Labrador-Grenfell RHAs indicated that unannounced or surprise monitoring visits at PCHs are carried out at the discretion of their staff. Staff in the Eastern, Central and Labrador-Grenfell RHAs are not required to complete a report to document the results of their unannounced visits at PCHs. Staff in the Western RHA are required to complete a report to document the results of their unannounced visits at PCHs.

  We found that the Eastern, Central and Western RHA staff write a note to the PCH electronic file indicating that an unannounced visit had occurred and whether any areas of concern were identified. However, this method of recording unannounced visits does not capture the extent of the monitoring activities that were performed by RHA staff and whether performance measures were being assessed. Furthermore, because data cannot be readily extracted from the staff notes in the PCH electronic files or from any related documentation in staff files, we were unable to readily determine the number of unannounced visits carried out and whether any areas of concern were identified.

  The Labrador-Grenfell RHA indicated that unannounced or surprise monitoring visits are not normally documented in the PCH file.

Findings

15. RHAs announce when they will be visiting PCHs to carry out monitoring activities for the purpose of completing quarterly and annual monitoring reports. Since these monitoring visits do not contain an element of surprise, the monitoring reports might not be a good indicator as to whether PCHs were complying with the PCH Operating Standards continuously throughout the year.

16. RHAs carry out unannounced monitoring visits for purposes other than to complete quarterly and annual monitoring reports. Our review indicated that the results of these unannounced monitoring visits carried out by the Eastern, Central and Western RHAs were not adequately documented and we were unable to readily determine the number of unannounced visits carried out and whether performance measures were being assessed. The Labrador-Grenfell RHA indicated that unannounced monitoring visits were not normally documented in the PCH file.

Quarterly Monitoring

The PCH Monitoring Framework identifies 12 of the 88 performance measures considered key for PCHs in maintaining resident care, program and service requirements, and should therefore be monitored quarterly by the RHAs. Table 5 shows the 12 performance measures that are monitored quarterly by the RHAs.

Table 5

Personal Care Homes
Performance Measures Monitored Quarterly by RHAs

	PCH Performance Measure
1	Staff and residents receive regular instructions in the fire safety plan.
2	Staff and residents receive regular instructions in the fire evacuation floor plan.
3	Residents' individual rights and privileges are respected at all times including confidentiality and personal privacy. Residents are involved in decisions that affect them.
4	A process is in place to identify and address any concerns that residents raise about their rights and privileges and are encouraged to become members of the homes' committees, where they exist.
5	The operator completes the individual's orientation to the home ensuring recording of all individual personal, medical, care, financial and advanced health care directive information …within the first week.
6	The operator monitors individuals to ensure they are adjusting well to their new home and community. Documentation is evident to support monitoring.
7	The operator reviews the medication policies as part of staff orientation and every three months with permanent staff. New polices are reviewed with staff immediately and every three months subsequently and recorded on the staff members file.
8	Operators meet the minimum staffing requirements in the PCH Operating Standards manual.
9	Operators meet the minimum hiring requirements for PCH staff outlined in the PCH Operating Standards manual.
10	The operator provides an orientation to all new employees.
11	The operator offers training sessions to staff.
12	The operator requires the written consent of the resident or an authorized individual prior to releasing any information to a third party.

Source: PCH Operating Standards, Department of Health and Community Services

Every quarter, RHA staff are required to visit PCHs, carry out monitoring procedures and complete monitoring reports to ensure these 12 performance measures were met by the PCHs. RHA staff normally meet and discuss the results of their visits with PCH management and provide direction as to the corrective action required to address any areas of concern.

Our review indicated that not all RHAs completed the required quarterly monitoring reports. Of the monitoring reports that were completed, in most cases, there was insufficient or inadequate evidence to support conclusions drawn by RHA staff that the PCHs had met the 12 performance measures and were complying with the PCH Operating Standards.

Table 6 shows the number of quarterly monitoring reports required and completed by RHAs, the percentage of performance measures met and the adequacy of supporting evidence, for the PCHs we reviewed during the two year period ended March 31, 2014.

Table 6

Personal Care Homes
Quarterly Monitoring Reports Required and Completed by RHAs, Percentage of Performance Measures Met and Adequacy of Supporting Evidence for PCHs Reviewed
Two year period ended March 31, 2014

RHA	Number of PCHs Reviewed	Monitoring Reports			Percentage of Performance Measures Met	Adequacy of Supporting Evidence (Percentage)		
		Required	Completed by RHA					
			Yes	No		Adequate	Inadequate	No Evidence
ERHA	16	128	128	0	94%	45%	26%	29%
CRHA	7	56	47	9	98%	12%	39%	49%
WRHA	5	40	40	0	97%	13%	17%	70%
LGRHA	2	16	10	6	100%	39%	38%	23%
Total	**30**	**240**	**225**	**15**	**97%**	**27%**	**30%**	**43%**

As Table 6 shows, for the 30 PCHs that we reviewed in the two year period ended March 31, 2014, the Central RHA did not complete 9 (16%) of 56 required quarterly reports and the Labrador-Grenfell RHA did not complete 6 (37%) of 16 required quarterly reports. For the 225 completed monitoring reports we reviewed, RHA staff indicated that PCHs met the 12 performance measures at an average rate of 97%. However, we found that where RHA staff concluded that the PCH had met each performance measure, there was not always evidence to support the conclusion or the evidence provided was inadequate. Specifically, we found that on average:

- 43% of the time, there was no evidence to support the conclusion.

- 27% of the time, there was sufficient, appropriate and reliable evidence to support the conclusion.

- 30% of the time, the evidence provided in support of the conclusions was inadequate (not sufficient, appropriate, reliable).

  For example, one of the 12 performance measures requires that PCHs meet minimum staffing requirements which states that, depending on the size of the PCH, there should be a specific number and type of staff on duty throughout the day to ensure resident services and care needs are addressed. The PCH Monitoring Framework requires that PCHs submit their staffing schedules to RHAs each quarter. RHA staff must review these schedules and determine whether the PCHs are meeting the staffing requirements. Our review indicated that the RHAs obtained PCH staffing schedules and determined that, in almost every case, PCHs were meeting staffing requirements. However, a staffing schedule does not provide sufficient, appropriate or reliable evidence that the PCH was meeting staffing requirements throughout the quarter because the staffing schedules do not provide evidence that the PCH staff actually worked the hours scheduled.

Finding

17. The Central and Labrador-Grenfell RHAs had not completed all the required quarterly monitoring reports for the 30 PCHs that we reviewed. Of the monitoring reports that were completed at all four RHAs, in 73% of the instances where RHA staff concluded that the PCH had met each performance measure, there was inadequate or no evidence to support the conclusion drawn. As a result, the RHA could not demonstrate that the PCHs were complying with the PCH Operating Standards at the high rates which they reported to the Department.

Non-Compliance with PCH Operating Standards Monitored Quarterly

Table 6 shows that PCHs were complying with the quarterly performance measures at a high rate of 97%. For the remaining 3%, we found that, in most cases, RHA staff identified that PCH staff did not meet minimum hiring requirements. The minimum hiring requirements specify that, prior to hiring, PCH staff must provide a:

- medical assessment if providing resident care and/or supervision;
- tuberculosis skin test and chest x-ray;
- record of immunization;
- certificate of conduct from the Royal Newfoundland Constabulary;
- pledge of confidentiality; and
- first aid certificate.

For the 30 PCHs we reviewed during the two year period ended March 31, 2014, we found that for:

- 17 (57%) of the 30 PCHs, the PCH staff did not meet one or more of the minimum hiring requirements in at least one of the eight quarterly visits;
- six (20%) of the 30 PCHs, the PCH staff did not meet one or more of the minimum hiring requirements in three or more consecutive quarterly visits; and
- five (17%) of the 30 PCHs, the PCH staff did not meet one or more of the minimum hiring requirements in all eight consecutive quarterly visits. All five of these PCHs were under the Eastern RHA.

Furthermore, we found instances where the RHAs identified PCH staff that did not have the required documentation on file (ie. medical assessment) but still concluded that the PCHs were complying with minimum hiring requirements. This occurred when the PCH subsequently obtained and provided the medical assessment to the RHA staff member. As such, the rate at which this performance measure was met was inflated.

Findings

18. PCH staff did not always meet the minimum hiring requirements specified in the PCH Operating Standards. For example, in five (17%) of the 30 PCHs we reviewed, the PCH staff did not meet one or more of the minimum hiring requirements in all eight consecutive quarterly visits.

19. There were instances where RHA staff concluded that PCHs were complying with minimum hiring requirements even though they found that the PCH did not have the required documentation on file. As such, the rate at which this performance measure was met was inflated.

Annual Monitoring

Once a year, RHA staff complete a review to determine whether the PCHs are meeting 76 performance measures identified in the PCH Monitoring Framework. RHA staff meet and discuss the results of their visits with PCH management and provide direction as to the corrective action required to address any areas of concern.

Table 7 shows the number of annual monitoring reports required and completed by RHAs, the percentage of performance measures met and the adequacy of supporting evidence, for the 30 PCHs we reviewed during the two year period ended March 31, 2014.

Table 7

Personal Care Homes
Annual Monitoring Reports Competed by RHAs, Percentage of Performance Measures Met and Adequacy of Supporting Evidence for PCHs Reviewed
Two year period ended March 31, 2014

RHA	Number of PCHs Reviewed	Annual Monitoring Reports		Percentage of Performance Measures Met	Adequacy of Supporting Evidence (Percentage)		
		Required	Completed		Adequate	Inadequate	No Evidence
ERHA	16	32	32	99%	41%	13%	46%
CRHA	7	14	14	100%	27%	17%	56%
WRHA	5	10	10	99%	22%	8%	70%
LGRHA	2	4	4	98%	20%	8%	72%
Total	**30**	**60**	**60**	**99%**	27%	12%	61%

As Table 7 shows, for the two year period ended March 31, 2014, RHAs completed the annual monitoring reports as required. For the 60 monitoring reports we reviewed, RHA staff indicated that PCHs met the 76 performance measures at an average rate of 99%. However, we found that where RHA staff concluded that the PCH had met each applicable performance measure, there was not always evidence to support the conclusion or the evidence provided was inadequate. Specifically, we found that on average:

- 61% of the time, there was no evidence to support the conclusion.
- 27% of the time, there was sufficient, appropriate and reliable evidence to support the conclusion.
- 12% of the time, the evidence provided in support of the conclusions was inadequate (not sufficient, appropriate, reliable).

Finding

20. The RHAs completed all of the required annual monitoring reports for the 30 PCHs that we reviewed. However, in 73% of the instances where RHA staff concluded that PCHs had met each performance measure, there was inadequate or no evidence to support the conclusion drawn. As a result, the RHAs could not demonstrate that the PCHs were complying with the PCH Operating Standards at the high rates which they reported to the Department.

Medication Storage Audits

The PCH Operating Standards manual requires that a pharmacist/nurse conduct a medication storage audit on an annual basis. This audit determines whether resident medication kept at the PCH is stored, secured and administered in accordance with the PCH Operating Standards, including whether medication is:

- stored in a secure area at the proper temperature;
- labelled in original containers identifying resident, prescribed dosage and expiry date;
- prescribed by a physician, dentist, nurse; and
- recorded on a Medication Administration Form when administered.

Our review indicated that for the 30 PCHs reviewed, the RHA did not provide evidence that an annual medication storage audit was performed by the pharmacist/nurse in 8 (13%) of the 60 audits required during the two years ended March 31, 2014. Five (62%) of the eight annual medication storage audits were not completed for PCHs under the Western RHA. Three (38%) of the eight annual medication storage audits were not completed for PCHs under the Central RHA.

Finding

21. The RHAs could not provide evidence that annual medication storage audits were performed by a pharmacist/nurse in 8 (13%) of the 60 audits required for the 30 PCHs we reviewed during the two year period ended March 31, 2014.

1B(iii). Complaints

Introduction

The PCH Operating Standards require that RHAs work with PCHs in addressing any complaints that the RHAs receive in a timely manner. In order to effectively manage the PCH complaints that it receives, RHAs should have PCH complaints policies, procedures and administrative records in place.

Complaints Policies, Procedures and Records

We asked each RHA to provide us with their complaints policies and procedures and a listing of the complaints that they received in connection with the 30 PCHs we reviewed during the two year period ended March 31, 2014. We found the following:

- The Eastern RHA had documented PCH complaints policies and procedures in place and maintained a database of complaints received. We reviewed a listing of the complaints provided and found that 30 complaints were received in connection with the 16 PCHs we reviewed. We reviewed the complaint forms and found that the complaints were addressed in a timely manner.

- The Central RHA had documented PCH complaints policies and procedures in place but did not maintain a database of complaints received and were unable to readily provide us with a listing of the complaints that they received. In addition, there was no standard form which the RHA could use to record the details of each complaint. We reviewed the complaint notes, emails and/or letters for 18 complaints received in connection with the seven PCHs we reviewed. We found that one of the 18 complaints was not addressed in a timely manner.

  On February 4, 2014, the RHA received a complaint related to numerous fire and life safety issues identified by the Fire Commissioner during the local fire department's inspection of a PCH on January 31, 2014. In May 2014, the fire chief for the town contacted the RHA and advised that the PCH had still not addressed all of the fire and life safety issues outstanding and were refusing to allow any further inspection by the local fire department. During this time, the RHA requested that the GSC carry out a fire and life safety inspection at the PCH, however, this inspection was never completed by the GSC. In February 2015, the local fire department wrote the RHA and advised that a follow-up inspection was carried out in January 2015 and that there were still outstanding fire and life safety issues at the PCH. The local fire department advised it would not be doing any more inspections and referred the matter to Service NL.

The RHA issued a four month temporary license to this PCH on July 31, 2014, with instructions to correct the issues identified in the fire department's January 2014 inspection report. These issues were not corrected when the temporary license expired on November 30, 2014. The RHA issued another temporary license after receiving assurance from the PCH that the outstanding fire and life safety issues would be corrected by the temporary license expiry date of March 27, 2015.

- The Western RHA did not have documented PCH complaints policies and procedures in place, but did maintain a database of complaints received. However, no standard form was used to record the details of each complaint. We reviewed the complaint notes, emails and/or letters for 14 complaints received in connection with the five PCHs we reviewed and found that the complaints were addressed in a timely manner.

- The Labrador-Grenfell RHA had documented PCH complaints policies and procedures in place, but did not maintain a database of complaints received and were unable to readily provide us with a listing of the complaints that they received. The Labrador-Grenfell RHA indicated that no complaints were received in connection with the two PCHs we reviewed.

Findings

22. The Western RHA did not have documented PCH complaints policies and procedures in place.

23. The Central and Labrador-Grenfell RHAs did not maintain a database of complaints received regarding PCHs and were unable to readily provide us with a listing of PCH complaints that they received during our review period.

24. One of 18 complaints received in connection with seven PCHs we reviewed under the Central RHA was related to serious fire and life safety issues at the home. We found that the complaint was not addressed in a timely manner by the Central RHA.

1B(iv). Resident Care Reassessments

RHAs assign clinical caseworkers to residents upon admission to the PCH to ensure that residents receive the level of care that they require. Each year, caseworkers must reassess residents to determine whether their level of care needs have changed and whether this change might require that the resident be placed in a long term care facility. Caseworkers must carry out and document their annual reassessment using a Long Term Care Reassessment (LTCR) tool.

Table 8 shows the number of reassessments required, completed, not completed and not completed on time for residents and PCHs reviewed during the two year period ended March 31, 2014.

Table 8

Personal Care Homes
Annual Reassessments Required, Completed, Not Completed and Not Completed on Time for Residents in PCHs Reviewed
Two year period ended March 31, 2014

RHA Region	Number Reviewed		Number of Reassessments			
	PCHs	Residents	Required	Completed	Not Completed	Not Completed on Time
Eastern	16	51	102	95	7	60
Central	7	27	54	44	10	24
Western	5	18	36	35	1	6
Labrador-Grenfell	2	4	8	0	8	n/a
Total	**30**	**100**	**200**	**174**	**26**	**90**

As Table 8 shows, we reviewed the annual long term care reassessments of 100 residents in 30 PCHs during the two year period ended March 31, 2014. We found that the required annual reassessments were not always completed and when they were completed, they were not always completed within a year of the prior reassessment. Specifically:

- 26 (13%) of 200 required annual reassessments were not completed. The Labrador-Grenfell RHA did not complete any of the eight required annual reassessments for the four residents we selected for review in two PCHs. The Central RHA did not complete eight required annual reassessments for four residents we selected for review in one of the seven PCHs.

- 90 (45%) of the required 200 annual reassessments were overdue, as they were not completed within a year of the prior annual reassessment. The number of days that the annual reassessments were overdue averaged 55 days and ranged from a high of 256 days to a low of one day.

Finding

25. Annual resident reassessments were not always completed as required. For example, 26 (13%) of 200 resident annual reassessments were not carried out in connection with 100 residents that we selected for review in 30 PCHs. Furthermore, when annual resident reassessments were completed, they were not always completed within a year of the prior reassessment as required. For example, 90 (45%) of 200 annual resident reassessments were not completed by RHAs within a year of the prior annual reassessment. The number of days that the annual reassessments were overdue averaged 55 days and ranged from a high of 256 days to a low of one day.

1C. Government Service Centre Inspections of PCHs

Overview

Service NL, through its GSCs, is responsible for monitoring the physical conditions of PCHs in accordance with the PCH Operating Standards. The PCH Operating Standards require that GSCs carry out an annual inspection of PCHs to determine whether the PCHs are complying with various health and safety legislation and standards, including the:

- National Building Code (adopted under the *Fire Protection Services Act*);
- National Fire Code (adopted under the *Fire Protection Services Act*);
- National Fire Life Safety Code (adopted under the *Fire Protection Services Act*);
- *Building Accessibility Act*;
- *Public Safety Act*;
- *Health and Community Services Act (Sanitation Regulations)*;
- *Food Premises Act and Regulations*;
- *Smoke-Free Environment Act and Regulations*;
- *Environment Protection Act;* and
- *Communicable Disease Act.*

Technical inspectors and environmental health inspectors (inspectors) located at various GSCs throughout the Province carry out these inspections. The results of the inspection activity are documented in inspection reports which are forwarded to the RHAs for PCH licensing purposes.

We reviewed the PCH Operating Standards and GSC inspection reports. We held discussions with RHA and GSC officials. We identified issues in the following areas:

i. Inspection Planning, Scheduling and Reporting
ii. Fire and Life Safety Inspections
iii. Environmental Health Inspections
iv. Food Premises Inspections

1C(i). Inspection Planning, Scheduling and Reporting

Introduction

In order for GSC inspections to be effective, they should follow a risk based approach. There should be an annual plan that identifies: the number of PCHs to be inspected; the life, health and safety risk associated with each PCH; and, the timing/frequency of inspections required to reduce any identified risks. PCHs identified as being a greater risk (ie: many residents, numerous complaints and poor inspection history) should be inspected more frequently to ensure compliance with the PCH Operating Standards. Inspection results should be documented on an inspection report which captures the key inspection information required for PCH monitoring and licensing purposes.

Our review indicated the following:

Inspection Planning and Scheduling

The *Regulations* state that the RHAs, in consultation with the GSCs, may determine the frequency of inspections that an inspector shall make in order to ensure compliance with the *Regulations* and required standards. We asked RHA and GSC officials whether the frequency of fire and life safety inspections and environmental health inspections was considered. We were advised by RHA and GSC officials that inspections were carried out based on the PCH Operating Standards requirement of one inspection per year and that a risk based approach to inspection frequency, where PCHs identified as being a higher risk are inspected more frequently, was not considered. As a result, we were unable to determine whether one GSC inspection per year was sufficient for ensuring that PCHs were complying with the legislation, codes and PCH Operating Standards continuously throughout the year.

PCHs in most RHA regions are licensed annually and the GSC must schedule and carry out an annual inspection at least 60 days prior to the date that the existing PCH license expires. Our review of inspection reports during the two year period ended March 31, 2014, indicated that approximately:

- 70% of the annual fire and life safety inspections were scheduled and carried out during the same month each year; and

- 70% of the annual environmental health inspections were scheduled and carried out during the same quarter each year.

Since PCHs knew approximately when GSC inspectors carry out inspections, they did not always contain the element of surprise, and as such areas of non-compliance could have been corrected by the PCH prior to the inspection. As a result, the inspection reports might not be a good indicator as to whether PCHs were complying with the PCH Operating Standards continuously throughout the year.

Finding

26. GSC inspections of PCHs were not being carried out using a risk based approach and did not always contain the element of surprise. As a result, the GSCs could not provide RHAs with sufficient assurance that PCHs were complying with the PCH Operating Standards on a consistent basis throughout the year.

Inspection Reports

An inspection report should be designed to capture key inspection information in a complete and accurate manner as this would serve to focus the inspector on the key inspection areas and ensure sufficient and appropriate compliance information is provided to the RHAs.

We found that the inspection reports did not identify the key inspection areas and did not reference the associated legislation or standards which would represent a threat to the life, health and safety of PCH residents and staff, if not complied with. We reviewed a sample of 168 inspection reports completed by technical and environmental health inspectors and found that numerous reports were difficult to read (some were illegible) and it was not always clear whether deficiencies identified were serious or not. In addition, clear instructions were normally not provided to the PCH as to the corrective action required.

In November 2010, officials from the Eastern RHA and the GSC met to discuss PCH inspection and licensing issues. The Eastern RHA raised concerns that GSC inspection reports were vague and that the Eastern RHA had difficulty determining whether the PCHs were complying with the life, health and safety legislation and standards. It was agreed that the inspection reports should be reviewed and standardized across all regions of the Province. However, we were unable to determine whether this review was ever completed.

Inspection reports used by inspectors to record the results of fire and life safety inspections and environmental health inspections were inadequate because they were not designed to provide RHAs with sufficient and appropriate information to determine whether PCHs were complying with the PCH Operating Standards and should continue to be licensed.

Finding

27. Inspection reports used by inspectors to record the results of fire and life safety inspections and environmental health inspections were inadequate because the reports did not identify key inspection areas and did not reference the associated legislation or standards which would represent a threat to the life, health and safety of PCH residents and staff, if not complied with.

28. We reviewed a sample of 168 inspection reports completed by technical and environmental health inspectors and found that numerous reports were difficult to read (some were illegible) and it was not always clear whether deficiencies identified were serious or not.

1C(ii). Fire and Life Safety Inspections

Introduction

Inspections are carried out at PCHs to ensure that the physical facilities comply with the requirements of the legislation, codes and standards specified in the PCH Operating Standards which relate to fire and life safety. These inspections are carried out under authority of the Provincial Fire Commissioner in accordance with the *Fire Prevention Services Act*. Such inspections protect residents from risk of injury, loss of life, and property damage associated with: the improper operation and use of pressure systems; hazardous gases; fires and explosions in and around buildings; and flammable product storage facilities. The PCH Operating Standards specifically state that PCHs must:

- have a fire safety plan on file with the GSC and local fire department;
- train staff in the fire safety plan;
- have a fire evacuation floor plan posted in conspicuous places throughout the PCH;
- provide staff and residents with regular instruction in the fire safety and evacuation plans;
- maintain heating, ventilation, fire alarm, sprinkler, fire extinguisher and fire suppression systems;
- carry out and record the results of daily fire and life safety security checks; and
- only install and maintain approved fuel fired appliances, propane and oxygen systems.

Table 9 shows the type and number of GSC fire and life safety inspections by RHA for the 30 PCHs that we reviewed during the two year period ended March 31, 2014.

Table 9

Personal Care Homes
Type and Number of GSC Fire and Life Safety Inspections by RHA for PCHs Reviewed
Two year period ended March 31, 2014

RHA	Number of PCHs Reviewed	2012-13				2013-14				Overall Total
		Number of Inspections				Number of Inspections				
		Routine	Follow Up	Other	Total	Routine	Follow Up	Other	Total	
Eastern	16	16	11	5	**32**	16	5	3	**24**	**56**
Central	7	6	0	0	**6**	2	0	0	**2**	**8**
Western	5	5	0	0	**5**	5	0	0	**5**	**10**
Labrador	2	2	0	0	**2**	2	0	0	**2**	**4**
Total	**30**	**29**	**11**	**5**	**45**	**25**	**5**	**3**	**33**	**78**

As Table 9 shows, GSC inspectors completed 78 inspections in connection with the 30 PCHs we reviewed during the two year period ended March 31, 2014. Of the 78 inspections completed:

- 54 were routine inspections that were carried out to determine whether the PCH was complying with the PCH Operating Standards;
- 16 were follow-up inspections that were carried out to determine whether deficiencies identified during routine inspections were corrected; and
- 8 were specific inspections mainly related to oxygen use by residents in the PCH.

Our review indicated the following:

Inspection Frequency

The PCH Operating Standards require the GSC to carry out an inspection at each PCH annually. We found that 24 (80%) of the 30 PCHs received an annual inspection as required in each of the two years ended March 31, 2013 and March 31, 2014. For the remaining six PCHs, which were under the Central RHA, we found that the PCHs did not receive one of the required annual inspections during the two year period ended March 31, 2014.

Finding

29. Six of the 30 PCHs we reviewed did not receive one of the required annual fire and life safety inspections during the two year period ended March 31, 2014. These PCHs were under the Central RHA.

Inspector Training

In 2012, the Engineering and Inspection Services Division of Service NL implemented a Province wide training program for technical inspectors that were assigned fire and life safety inspection duties. In order to qualify for fire and life safety inspections of PCHs, the inspector must complete a certified fire inspector training program or an in-house training and mentoring program. Our review of the training records for inspectors that were carrying out fire and life safety inspections of PCHs during the two year period ended March 31, 2014, indicated that two inspectors in the Western GSC did not have the required training to carry out such inspections.

Finding

30. Two inspectors in the Western GSC did not have the required training to carry out fire and life safety inspections during the two year period ended March 31, 2014.

Inspection Results - Critical Deficiencies

Critical fire and life safety deficiencies are those which pose a risk to the life, health and safety of residents and must be corrected immediately or within a short timeframe. As the inspection reports used by inspectors to document the results of their inspections do not identify critical areas of the inspection, we asked the St. John's GSC to provide us with a list of the critical areas. GSC officials advised that critical areas of inspection include the PCHs' fire protection system and ancillary equipment (fire detection, alarm, suppression, extinguisher and sprinkler systems, fire doors, fire walls, emergency lighting) and resident use of oxygen. These critical systems must be inspected annually by contractors registered with the Provincial Fire Commissioner. PCHs identified with expired fire protection system certificates must immediately book an inspection with a registered contractor.

Our review of 54 routine inspection reports in connection with the 30 PCHs we examined during the two year period ended March 31, 2014 indicated that in 36 (67%) of the 54 inspections, for 21 of the 30 PCHs, an inspection identified 150 critical deficiencies which required immediate correction or correction within a short timeframe. Examples of the critical deficiencies identified included:

- fire alarm system requires repair;
- fire alarm certificate out of date;
- emergency lighting system failure; and
- fire door in need of repair.

In 16 (11%) of the 150 critical deficiencies identified, in connection with seven of the 30 PCHs, we were unable to determine from the inspection reports whether the deficiency had been corrected. Furthermore, in nine (6%) of the 150 critical deficiencies in connection with six of the 30 PCHs, the same deficiency was identified in the following annual inspection.

Finding

31. We were unable to determine whether 16 critical fire and life safety deficiencies identified by GSC inspectors in seven of the 30 PCHs we reviewed, had been corrected immediately or within a very short timeframe. Furthermore, in six PCHs, the same nine critical deficiencies were identified by a GSC inspector in the following annual inspection.

Inspection Results - Non Critical Deficiencies

Non-critical fire and life safety deficiencies are aspects at the PCH that are not considered a significant risk to the life and safety of residents and would not require immediate correction or correction within a short timeframe. However, the nature and number of deficiencies and the length of time that the deficiencies exist, all contribute to resident life and safety risk at the PCH.

Our review of 54 routine inspection reports, in connection with the 30 PCHs we examined during the two year period ended March 31, 2014, indicated that in 32 (59%) of the 54 inspections for 19 of the 30 PCHs, the inspector identified 107 non-critical deficiencies which required correction within a timeframe that should have been specified by the Inspector. Examples of the non-critical deficiencies identified included:

- stairwell to kitchen not cleared;
- fridge not in an appropriate location;
- fire extinguisher sign not installed properly; and
- fire extinguisher incorrectly dated on tag.

We found the following:

- In 61 (57%) of the 107 non-critical deficiencies identified, in connection with 14 of the 30 PCHs, the deficiency was corrected immediately.
- In 31 (29%) of the 107 non-critical deficiencies identified, in connection with 10 of the 30 PCHs, the inspector did not provide a timeframe by which the deficiency should be corrected and we were unable to determine whether 17 (55%) of the 31 deficiencies were ever corrected.
- In 29 (63%) of the 46 non-critical deficiencies identified that were not corrected immediately, in connection with six of the 30 PCHs, the inspector did provide a timeframe by which the deficiency should be corrected; however, we were unable to determine whether the deficiencies were ever corrected.
- Furthermore, in eight (7%) of the 107 non-critical deficiencies identified, the same deficiency was identified in the previous or following annual inspection.

Findings

32. GSC inspectors did not always provide PCHs with a timeframe to correct non-critical fire and life safety deficiencies. Timeframes for correction were not provided for 31 (29%) of the 107 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed.

33. We were not always able to determine whether non-critical deficiencies identified during inspections were ever corrected by the PCHs. We could not determine whether 46 (43%) of the 107 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed, were ever corrected.

Inspection Results - Operating Standard Requirements

The PCH Operating Standards identify specific fire and life safety requirements which must be complied with. GSC inspection reports should indicate whether PCHs are complying with these specific requirements so that RHAs can determine whether PCHs may continue to be licensed. Our review of 54 routine inspection reports in connection with 30 PCHs during the two year period ended March 31, 2014 indicated that:

- In 20 (37%) of 54 inspection reports reviewed, the inspector did not indicate in the inspection report whether the PCH was properly maintaining one or more of the following required fire protection systems: sprinkler system; fire suppression system; fire detection and alarm system; and fire extinguisher system.

- In 42 (78%) of the 54 inspection reports reviewed, the inspector did not indicate in the inspection report whether the PCH was using and properly maintaining one or more of the following systems: fuel fired systems; propane systems; and oxygen systems.

- In 53 (98%) of the 54 inspection reports reviewed, the inspector indicated that the PCH was carrying out daily security checks to ensure fire and life safety requirements were being maintained in the PCH, including whether: exit doors were operating; exit and emergency lights were working; fire extinguishers were current and operable; corridors were free of obstacles and outside stairs and steps were free of snow and ice. However, we found that in 45 (85%) of the 53 inspection reports where the inspector indicated that daily security checks were being carried out by the PCH, the inspector had identified one or more fire and life safety violations that the PCH had not addressed during their required daily security checks. When PCHs fail to address fire and life safety issues during daily security checks, this information should be conveyed to the RHAs for their consideration when re-licensing PCHs.

Finding

34. Inspection reports for the 30 PCHs that we reviewed did not always indicate whether PCHs were complying with specific fire and life safety requirements in the PCH Operating Standards. For example, in 42 (78%) of 54 fire and life safety inspection reports, the inspector did not indicate whether the PCH was using and properly maintaining fuel fired, propane and oxygen systems.

Inspection Results - Reporting

The PCH Operating Standards require that GSCs provide the RHAs with all fire and life safety inspection reports completed for PCHs. We found that fire and life safety inspection reports were provided to RHAs as required, for the 30 PCHs that we reviewed.

There is no requirement in the PCH Operating Standards that the GSCs provide the results of fire and life safety inspections to the public. However, such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Finding

35. For the 30 PCHs examined, fire and life safety inspection reports were provided to RHAs by the GSCs as required. However, there is no requirement in the PCH Operating Standards for the results of fire and life safety inspections to be made available to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

1C(iii). Environmental Health Inspections

Introduction

Environmental health inspections are carried out at PCHs to ensure that the physical facilities comply with the requirements of the legislation, codes and PCH Operating Standards so that the health and well-being of residents is protected. These inspections are carried out in accordance with the Department of Health and Community Services Closed Residential Facilities Policy which requires that PCHs receive a minimum of one inspection per year in accordance with the Environmental Health Guidelines that were established by the Department. Areas of inspection identified under the guidelines include: the building and surrounding environment; water and sewage; plumbing; ventilation; lighting; pets; toilet and shower facilities; laundry and housekeeping; solid waste removal; chemical storage; and food service.

Table 10 shows the type and number of GSC environmental health inspections by RHA for the PCHs that we reviewed during the two year period ended March 31, 2014.

Table 10

Personal Care Homes
Type and Number of GSC Environmental Health Inspections by RHA for PCHs Reviewed
Two year period ended March 31, 2014

RHA Region	Number of PCHs Reviewed	2012-13				2013-14				Overall Total
		Number of Inspections				Number of Inspections				
		Routine	Follow Up	Other	Total	Routine	Follow Up	Other	Total	
Eastern	16	24	6	3	**33**	21	1	4	**26**	**59**
Central	7	7	0	0	**7**	7	0	0	**7**	**14**
Western	5	5	0	0	**5**	6	0	0	**6**	**11**
Labrador	2	2	0	0	**2**	3	0	1	**4**	**6**
Total	**30**	**38**	**6**	**3**	**47**	**37**	**1**	**5**	**43**	**90**

As Table 10 shows, GSC inspectors completed 90 inspections in connection with the 30 PCHs we reviewed during the two year period ended March 31, 2014. Of the 90 inspections completed:

- 75 were routine inspections that were carried out to determine whether the PCH was complying with the PCH Operating Standards;
- 7 were follow-up inspections that were carried out to determine whether deficiencies identified during routine inspections were corrected; and
- 8 were specific inspections mainly related to illness outbreaks.

Our review indicated the following:

Inspection Frequency

The PCH Operating Standards require the GSC to carry out an inspection at each PCH annually. We found that all 30 PCHs received an annual routine inspection as required in each of the two years ended March 31, 2013 and March 31, 2014.

Finding

36. All 30 PCHs that we reviewed had received an annual environmental health inspection as required by the PCH Operating Standards.

Inspection Results - Critical Deficiencies

Critical environmental health safety deficiencies are aspects at the PCH which pose an immediate risk to the health and safety of residents and must be corrected immediately or controlled. As the inspection reports used by inspectors to document the results of their inspections do not identify critical areas of the inspection, we asked the St. John's GSC to provide us with a list of critical areas of inspection. GSC officials advised us that there is no listing of critical inspection areas where a violation would pose an immediate danger to the health and safety of PCH residents, and that the identification of such violations would be at the discretion of the inspector.

Our review of 75 routine inspection reports in connection with the 30 PCHs we examined during the two year period ended March 31, 2014 indicated that in 9 (12%) of the 75 inspections, in connection with 7 of the 30 PCHs we reviewed, the inspector identified 11 critical deficiencies which required immediate correction or control. Examples of the critical deficiencies identified included:

- chemical bottles not properly labeled;
- soiled laundry not properly removed;
- washroom soiled; and
- asbestos discovered.

In 2 (18%) of the 11 critical deficiencies identified, in connection with 2 of the 30 PCHs we reviewed, we were unable to determine from the inspection report whether the deficiency had been corrected or controlled.

Finding

37. We were unable to determine whether two critical environmental health deficiencies identified by GSC inspectors in two of the 30 PCHs we reviewed, had been corrected immediately or were controlled.

Inspection Results - Non Critical Deficiencies

Non-critical environmental health deficiencies are aspects at the PCH that are not considered an immediate risk to the health and safety of residents and would not require immediate correction or control. However, the nature and number of deficiencies and the length of time that the deficiencies exist, all contribute to resident health and safety risk in the PCH.

Our review of 75 routine inspection reports in connection with the 30 PCHs we examined during the two year period ended March 31, 2014 indicated that in 41 (55%) of the 75 inspections, in connection with 23 of the 30 PCHs we reviewed, the inspector identified 79 non-critical deficiencies which required correction within a timeframe that should have been specified by the inspector. Examples of the non-critical deficiencies identified included:

- seats or armrest on chairs to be replaced;
- seal on exit door to be replaced;
- no protective seal on fluorescent light; and
- no sanitizer in washrooms.

We found the following:

- In 19 (24%) of the 79 non-critical deficiencies identified, in connection with 11 of the 30 PCHs we reviewed, the inspector did not provide a timeframe by which the deficiency should be corrected and we were unable to determine whether 18 (95%) of the 19 deficiencies were ever corrected.
- In 60 (76%) of the 79 non-critical deficiencies identified, in connection with 17 of the 30 PCHs we reviewed, the inspector did provide a timeframe by which the deficiency should be corrected; however, we were unable to determine whether 41 (68%) of the 60 deficiencies were ever corrected.
- In 4 (5%) of the 79 non-critical deficiencies identified, the same deficiency was identified in the following annual inspection.

Findings

38. GSC inspectors did not always provide PCHs with a timeframe to correct non-critical environmental health deficiencies. Timeframes for correction were not provided for 19 (24%) of the 79 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed.

39. We were not always able to determine whether non-critical deficiencies identified during inspections were ever corrected by the PCHs. We could not determine whether 59 (75%) of the 79 non-critical deficiencies that were identified, in connection with the 30 PCHs we reviewed, were ever corrected.

Inspection Results - Reporting

The PCH Operating Standards require that GSCs provide the RHAs with all environmental health inspection reports completed for PCHs. We found that environmental health inspection reports were provided to RHAs as required, for the 30 PCHs that we reviewed.

There is no requirement in the PCH Operating Standards that the GSCs provide the results of environmental health inspections to the public. However, such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

Finding

40. For the 30 PCHs we examined, environmental health inspection reports were provided to RHAs by the GSCs as required. However, there is no requirement in the PCH Operating Standards for the results of environmental health inspections to be made available to the public. Such information would be beneficial for the public, residents and families when evaluating the services of a PCH.

1C(iv). Food Premises Inspections

Introduction

Environmental health inspectors carry out inspections of food premises located in PCHs in order to protect the health of PCH residents in the area of food safety. Inspectors plan, schedule and carry out inspections of PCHs in accordance with the Department of Health and Community Services Inspection Frequency Risk Management Initiative. Unlike fire and life safety and environmental health inspections, the planning and scheduling of inspections is based upon the health risk assigned to the food premises by the inspector. Each year, inspectors must complete a risk assessment worksheet and calculate the level or risk (low, moderate or high) for each food premises. Generally, for food premises located in PCHs, the risk is assessed as either moderate or high as the resident population is elderly. As a result, food premises located within PCHs are normally inspected a minimum of two (moderate risk) or four (high risk) times per year. Inspection results are documented in a Food Premises Inspection Report.

Inspection Frequency and Results

During the two year period ended March 31, 2014, we reviewed 167 food premises inspection reports in connection with the 30 PCHs that we examined. We found the following:

- Food premises within PCHs were being inspected in accordance with the frequency required by the Department of Health and Community Services Frequency Risk Management Initiative.

- Food premises inspection reports were appropriately designed and captured results of the critical areas of inspection. In most all cases, inspectors completed the inspection reports we reviewed in a complete and accurate manner.

- The PCH Operating Standards do not require, and the GSCs do not forward the results of food premises inspections to the RHAs for licensing and monitoring purposes.

- The results of food premises inspections (inspection reports) are not provided to the public, even though the results of other food premises inspections, such as restaurants, are provided to the public.

Findings

41. Food premises located in PCHs were inspected in accordance with the frequency required by the Department. Furthermore, for the 167 food premises inspection reports we examined, in connection with the 30 PCHs that we reviewed, the majority of the inspection reports were completed in a complete and accurate manner.

42. The PCH Operating Standards do not require, and the GSCs do not forward the results of food premises inspections to the RHAs for licensing and monitoring purposes.

43. The results of food premises inspections of PCHs are not required to be provided to the public, even though the results of other food premises inspections, such as restaurants, are made available to the public.

Recommendations

1. The Department should complete a comprehensive review of the PCH Operating Standards and RHA monitoring methods, every two years as required.

2. The Department should consider reporting the results of RHA monitoring of PCHs to the public.

3. The Eastern, Central and Labrador-Grenfell RHAs should only license PCHs when they comply with the PCH Operating Standards.

4. The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with the PCH Operating Standards.

5. The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.

6. The Eastern, Central and Western RHAs should ensure that PCH staff meet the minimum hiring requirements as required.

7. The Western RHA should implement complaints policies and procedures to ensure complaints are resolved in a timely manner. The Central RHA should resolve all complaints in a timely manner.

8. The four RHAs should carry out resident care reassessments annually as required.

9. The GSCs should consider implementing a risk based approach to conducting inspections of PCHs.

10. The GSCs should revise inspection reports to identify key inspection areas including references to appropriate codes, standards and legislation.

11. The GSCs should carry out annual fire and life safety inspections of PCHs at least once per year as required.

12. The GSCs should ensure that technical inspectors are trained to carry out fire and life safety inspections of PCHs as required.

13. The GSCs should ensure that critical deficiencies identified in PCHs are corrected immediately or within the timeframe specified.

14. The GSCs should provide PCHs with timeframes to correct non-critical deficiencies identified during inspections and ensure that the deficiencies are corrected within the timeframes specified.

15. The GSCs should consider reporting the results of inspections of PCHs to the public.

16. The GSCs should conduct fire and life safety inspections and environmental health inspections at least 60 days prior to the license renewal date and recommend whether PCHs should continue to be licensed as required.

Department of Health and Community Services Response

Recommendations:

1. ***The Department should complete a comprehensive review of the PCH Operating Standards and RHA monitoring methods, every two years as required.***

   Response:
   While a formal comprehensive review of the PCH Operational Standards was not completed, the Department has been reviewing and making modifications to the Standards as issues arise. In these instances, clarification where required, has been provided in the form of memos to the regional health authorities, Service NL or personal care homes. The Department is currently conducting the required comprehensive review of the PCH Operating Standards and the Monitoring Framework. A working group with representation from the RHAs has been established to facilitate this process. The Department will also consult with Service NL and the PCH sector when drafts of the revised Standards are available.

2. ***The Department should consider reporting the results of RHA monitoring of PCHs to the public.***

   Response:
   The Department welcomes this recommendation and is open to working with the RHAs, Service NL and the PCH industry to develop a mechanism for public reporting.

Eastern Regional Health Authority Response

Recommendations:

3. ***The Eastern, Central and Labrador-Grenfell RHAs should only license PCHs when they comply with the PCH Operating Standards.***

   Response:
   Eastern Health works with Personal Care Home Operators to address issues of noncompliance. When serious issues of noncompliance are identified, Eastern Health will develop corrective action plans with Personal Care Homes. Eastern Health will issue conditional licenses or extension of licenses when warranted.

   Eastern Health acknowledges there are systemic issues with enforcing compliance with minimum hiring standards as noted by the Auditor General in Recommendation # 6.

4. ***The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with the PCH Operating Standards.***

   Response:
   The Eastern Health Personal Care Home Team have clinical staff who visit Personal Care Homes for the purpose of providing resident specific services, in addition to monitoring the compliance of Personal Care Homes with the Provincial Operating Standards.

   If a PCH is identified as having difficulties achieving compliance, Eastern Health staff will work with the operators on issue identification and resolution.

   As noted by the Auditor General on page 24 of his report, Eastern Health does require at least one unannounced /surprise visit to be completed by either the Community Health Nurse or Social Worker quarterly and at least one unannounced visit annually by the Dietitian. While Eastern Health does not require staff to document these findings on a specific report, staff are required to document their visit and any issues of note in the electronic PCH file within CRMS. Furthermore, Eastern Health has provided guidelines to assist staff in their monitoring visits.

   Eastern Health staff will also address issues of non-compliance if noted when completing resident specific visits. Resident specific visits are not always announced to the operator in advance.

   EH will continue to complete unannounced visits if necessary to address complaints or allegations of non-compliance.

5. ***The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate, and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.***

   Response:
   Currently, there is not a requirement to document the evidence found by the RHA staff in support of their conclusion. RHA staff are provided indicators to assist them in their assessment of PCH's compliance with provincial standards. It is a professional decision as to what evidence is documented. Normally, staff will document areas where compliance may be an issue, or note new initiatives, or improvements within a PCH.

   Eastern Health is willing to engage with the other RHAs and Department of Health and Community Services to determine acceptable standards of providing evidence to support RHA staff's decisions.

6. ***The Eastern, Central and Western RHAs should ensure that PCH staff meet the minimum hiring requirements as required.***

   Response:
   As noted in our response to Recommendation # 3, Eastern Health acknowledges that there is difficulty in Personal Care Homes achieving compliance in this area. Eastern Health counsels PCH operators of the liabilities that operators could be exposed to if they hire staff who do not meet the minimum hiring requirements. However, this issue is widespread and not easily resolved as operators cite difficulties in hiring staff who possess the qualifications. This is especially so when immediate, short term, or temporary relief positions are required. Eastern Health continues to identify these issues to operators and has on occasion noted concerns in licensing letters. Eastern Health would be pleased to work with the other RHAs, Department of Health and Community Services, and the Personal Care Homes Industry to seek solutions to increase compliance with this standard and to determine appropriate actions to take when minimum hiring standards are not met.

8. ***The four RHAs should carry out resident care reassessments annually as required.***

   Response:
   The Auditor General noted that of 102 required reassessments, Eastern Health did not complete seven required reassessments and that 60 reassessments were not completed on time. The number of days the annual reassessments were overdue averaged 55.2 days and ranged from 1 day to 256 days. 34 of these reassessments were completed less than 30 days after the anniversary date of the last reassessment. Eastern Health would not consider these 34 assessments to be overdue.

Long Term Care Reassessments are completed annually unless there are evident concerns which require the assessments to be completed earlier. As of December 31, 2014 there were 1623 residents in PCHS licensed by Eastern Health. A full time PCH Case Manager in Eastern Health will have an average caseload of 110 residents and will also be required to monitor standards compliance of 7 to 8 PCHs.

Case Managers are expected to complete the reassessment in the 12th month following the last reassessment. It is an acceptable practice for an assessment to be completed any time during the month the assessment is due.

As with any clinical assessment or intervention, Case Managers are expected to prioritize urgent reassessments. If circumstances require Case Managers to delay reassessments due to unforeseen or urgent issues, they are expected to prioritize the remaining or overdue reassessments based on risk.

Eastern Health is currently developing a new electronic data system which will provide a monthly report on upcoming due and overdue reassessments to PCH Case Managers and the Regional Manager to support timeline compliance.

Central Regional Health Authority Response

Recommendations:

3. ***The Eastern, Central and Labrador-Grenfell RHAs should only license PCHs when they comply with the PCH Operating Standards.***

   Response:
   Central Health works with Personal Care Home Operators to address issues of Standards' violations. The issuing of Interim licenses, when there are deficiencies, is guided by non-compliant protocol outlined in the Provincial PCH Operational Standards. The operational standards clearly suggest that the onus is on the RHA and Service NL Inspectors to work with the PCHs to correct any deficiencies. Corrective action is taken by the RHA when issues remain outstanding or the appropriate action is not taken by the operator to correct the deficiency.

   The RHA monitoring staff will work with Service NL to ensure the timely coordination of receiving Fire Life and Safety Certificates such as Fire Alarm Inspection, Fire Extinguisher inspection and Sprinkler inspections as part of the Annual Review Process.

   Central Health is working to improve coordination of the licensing process with Service NL. The RHA will forward a schedule of Annual Review dates to Service NL to ensure there is an opportunity to complete required Fire Life and Safety inspections.

4. ***The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with PCH Operating Standards.***

   Response:
   The Central Health Personal Care Home monitoring team members complete frequent visits both announced and unannounced to PCHs in the Central Region. Central Health collects monthly statistics for all nursing, social work and dietician visits. All visits to a personal care home by the monitoring team members include monitoring activities in addition to clinical activities. Issues of concern are reported to the PCH coordinator and are documented in the Client Referral and Management System (CRMS). The regional dietician also completes at minimum one unannounced annual visit.

   Central Health will develop and implement a regional policy to provide direction on the requirement for unannounced visits by all members of the monitoring team including guidelines for the documentation of unannounced visits.

5. The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.

Response:

Central Health acknowledges that there is difficulty in achieving compliance with respect to the requirement for quarterly monitoring. Central Health has taken corrective action to improve compliance with this standard including the development of schedules and reminders for monitoring; realignment of social worker caseloads and scope of practice to increase availability of social workers with expertise and experience in the personal care home sector; and the addition of one personal care home coordinator.

Central Health will continue to focus on continuous improvement in this area through the completion and tracking of quarterly monitoring meetings by RHA coordinators and the exploration of additional opportunities for caseload realignment in the personal care home program.

There is currently no requirement to document or attach the evidence utilized by the RHA in forming the conclusions that they make as part of the quarterly and annual reporting process. This evidence comprises a large volume of documentation and most of it is in paper format. While copies of reports are not attached to the monitoring reports, there is written confirmation that the reports have been reviewed. Central Health will enhance this process by having the monitoring team document in the comments section of the quarterly/annual reports the location of any documents utilized to validate decisions.

The selection of "no comments" or "not applicable" as a response in the evidence section may be an appropriate response in some areas where there has been no activity to monitor. Examples of standards that cannot be measured due to lack of activity include the following:

PCH must notify RHA 90 days before expected closure.	*n/a*
PCH must notify residents 90 days before expected closure.	*n/a*
RHA must be provided 60 days' notice re sale.	*n/a*
New operators must be licensed by RHA prior to assuming responsibility of PCH operation.	*n/a*

The Medication Storage Audits reports were not received by the RHA for (3) three personal care homes in 2012-2013. In the past, the personal care home operator had the flexibility to submit required documentation following an annual licensing review. This practice resulted in the absence of audit forms on (3) three occasions. The RHA coordinators have implemented new protocol to ensure the submission of the medication storage audits. The addition of one personal care home coordinator has improved the monitoring of personal care home submissions to the RHA. No missing documentation from the personal care homes has been noted since the 2012-2013 year. The RHA will continue to ensure the submission of all required documentation including the Medication Storage Audit happens prior to the annual licensing review.

6. ***The Eastern, Central and Western RHAs should ensure that PCH staff meet the minimum hiring requirements as required.***

   Response:
   Central Health does acknowledge that there are challenges in achieving full compliance in this area and will continue to counsel PCH operators with respect to the requirements for training. Central Health monitoring staff will continue to highlight the requirement for timely training and retraining.

7. ***The Western RHA should implement complaints policies and procedures to ensure complaints are resolved in a timely manner. The Central RHA should resolve all complaints in a timely manner.***

   Response:
   Central Health acknowledges that one centralized database was not used to capture all complaints related to personal care homes. Central Health will implement a policy and procedure whereby all personal care home complaints will be tracked within the organization's Compliments and Complaints database. Central Health makes every effort to resolve complaints in a timely manner and will continue to ensure that there is due diligence in this area.

8. ***The four RHAs should carry out resident care reassessments annually as required.***

   Response:
   The Auditor General has noted that of the 54 annual resident care reassessments required, 44 assessments were completed with 24 of these being outside the annual time frame. There were 10 annual assessments that were not completed. Central Health acknowledges that there are challenges with ensuring that all resident care reassessments are completed in a 12 month period. Central Health will review current case management processes to ensure that Case Managers are setting priorities with respect to annual reassessments.

   Central Health will implement an internal tracking system whereby all annual resident reassessment reports will be available for monitoring purposes to assist in ensuring compliance with this standard.

Western Regional Health Authority Response

Recommendations:

4. ***The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with PCH Operating Standards.***

   Response:
   Western Health conducts unannounced visits to PCHs in the Western region. For example in 2014 our Regional Nutritionist completed nine unannounced visits. Western Health acknowledges there may be further opportunity to document the existing frequency of unannounced visits to PCHs. Western Health is willing to work with the DHCS and other RHAs to establish a policy regarding unannounced visits and how they can be expanded upon to further augment monitoring of PCHs.

5. ***The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.***

   Response:
   Western Health follows the Monitoring Framework for Provincial Personal Care Home Standards, September 2007. Western Health is committed to ensuring documentation standards support the requirements for evidence to validate the compliance with operational standards and performance measures. Western Health has already consulted with other regions regarding their practices and will move forward to implement consistent practices. Western Health will work with staff to review requirements for documentation in quarterly and annual monitoring reports.

6. ***The Eastern, Central and Western RHAs should ensure that PCH staff meet the minimum hiring requirements as required.***

   Response:
   Western Health recognizes the importance of monitoring PCH compliance with standards related to hiring of staff. In 3 of 40 quarterly reports and 1 of 10 Annual Reports reviewed, minimum hiring requirements were not met by the PCHs. In these cases, non-compliance with standards was indicated by the nurse in the monitoring report, as required. As well, the nurse followed up with the homes in writing to highlight the need for action to meet the standards. In the future, Western Health will provide clarification to Western Health staff, PCH Owners and Operators that all documentation must be on file as required under Section 4 Standard 7-Staffing-Minimum Requirements for Personal Care Home Staff. Western Health will work with the other RHAs and DHCS to seek a consistent approach to follow when hiring requirements are not met and the level of sanction to be applied when this occurs.

7. The Western RHA should implement complaints policies and procedures to ensure complaints are resolved in a timely manner. The Central RHA should resolve all complaints in a timely manner.

Response:
Western Health has dealt with all complaints related to PCHs in a timely manner and maintains a database of complaints received. We have followed the requirements established in the PCH Standards under Section 1 Standard 3, however, Western Health acknowledges the importance of having a formal policy. Therefore, Western Health will revise our current Client Feedback - Compliments and Complaints policy (6-04-60) to include direction for PCHs. Once this policy is implemented, Western Health will utilize a standard form to record the details of each complaint in a manner consistent with all other complaints received by the organization. All complaints will continue to be maintained in an established database.

8. The four RHAs should carry out resident care reassessments annually as required.

Response:
Western Health had 1 client annual reassessment incomplete in 2013 and 6 that were not completed on time ranging from 4 to 110 days overdue. Our practice has been when an assessment is completed within the month it is due, it is considered to be complete. Therefore, we would have had 4 incomplete (average 45 days overdue) as the other two (completed 4 and 6 days from due date) would have been completed within the month they were due. For example, an assessment completed on January 15, 2014 would be due in January 2015 and completion on any day in January would be considered complete.

Western Health acknowledges that having a reassessment overdue up to 110 days is concerning. Western Health will insure the use of a KIV system within our electronic documentation system to support timely reassessments of residents. Western Health will monitor to ensure all clients receive an annual reassessment within the established timeframe. In conjunction, when reassessments cannot be completed due to resident illness, hospitalization or scheduling conflict Community Health Nurses will be required to document when and why assessments are delayed in the Client Referral Management System (CRMS) file.

Labrador-Grenfell Regional Health Authority Response

Recommendations:

3. ***The Eastern, Central and Labrador-Grenfell RHAs should only license PCHs when they comply with the PCH Operating Standards.***

   Response:
   Labrador-Grenfell Health agrees with the Auditor General's recommendation and supports the view that the Regional Health Authority will only license Personal Care Homes when they are in compliance with the Personal Care Home Operating Standards, as established by the Department of Health and Community Services. Labrador-Grenfell Health has developed and implemented an auditing process to ensure licensing requirements are met as outlined in the Personal Care Home Operating Standards. This process will validate that all documentation has been received, verifying that licensing requirements have been met before a license is granted.

   Labrador-Grenfell Health commits to formulating a policy that will outline the process for granting and/or renewing licenses, as set out in the Personal Care Home Operating Standards.

4. ***The four RHAs should consider the merit of carrying out surprise monitoring visits of PCHs when determining whether PCHs are complying with the PCH Operating Standards.***

   Response:
   Labrador-Grenfell Health has conducted unannounced visits during its monitoring activities, but acknowledges that both announced and unannounced visits have not been documented in the Client and Referral Management System (CRMS). Labrador-Grenfell Health commits to documenting monitoring activities in CRMS and formulating a policy that will outline the process for monitoring Personal Care Homes, as set out in the Personal Care Home Operating Standards.

5. ***The Central and Labrador-Grenfell RHAs should complete quarterly monitoring reports, which include the relevant PCH Operating Standards, as required. The four RHAs should ensure there is sufficient, appropriate and reliable evidence to support conclusions made in the quarterly and annual monitoring reports.***

   Response:
   Labrador-Grenfell Health agrees with the recommendation of the Auditor General that quarterly monitoring reports must include the appropriate evidence to support the conclusions contained in the corresponding report. Labrador-Grenfell Health carries out quarterly and annual monitoring activities at Personal Care Homes in accordance with the Monitoring and Quality Frameworks.

Labrador-Grenfell Health will update the quarterly monitoring report reflecting the 12 performance measures contained in the Personal Care Home Monitoring Framework. The checklist will document evidence of compliance and verify that performance measures have been met. More importantly, the auditing tool will provide the Personal Care Home Coordinator with a guideline to direct the Personal Care Home operator in taking corrective action.

Labrador-Grenfell Health commits to enforcing timeframes for conducting quarterly monitoring, and documenting the results in CRMS.

8. The four RHAs should carry out resident care reassessments annually as required.

Response:
Labrador-Grenfell Health agrees with the recommendation of the Auditor General that resident reassessments must be completed on an annual basis as required by the Personal Care Home Operating Standards. In response to the Auditor General's recommendation, all assessments and reassessments have been completed and an auditing tool has been implemented to track and monitor the reassessment process.

Service NL Response

Recommendations:

9. ***The GSCs should consider implementing a risk based approach to conducting inspections of PCHs.***

   Response:
   The standards for frequency and timing of inspections for Personal Care Homes are set in accordance with the PCH Operating Standards established by the Department of Health and Community Services and the Regional Health Authorities. While there is a minimum of one inspection required annually, inspectors can and do inspect facilities more frequently if issues require follow up or if there are concerns with compliance. However, Service NL will work with HCS and the RHAs to review the inspection requirements for these facilities.

   As a point of clarification with respect to your finding (#25) regarding a lack of the element of surprise, while it is acknowledged that many of these inspections are conducted in the same fiscal quarter of the year, our normal protocol is that there is no advance notice or scheduling of these routine inspections by our staff. As such, while an operator may expect an inspection within a given three month period, the exact timing of the inspection would not be known. However, we will also include this issue in our review.

10. ***The GSCs should revise inspection reports to identify key inspection areas including references to appropriate codes, standards and legislation.***

    Response:
    As part of a review of inspection forms and formats, Service NL has already started a review of the forms for PCH inspections to ensure they are both effective and efficient in conveying the appropriate information required by operators to comply with relevant codes, standards and legislation.

11. ***The GSCs should carry out annual fire and life safety inspections of PCHs at least once per year as required.***

    Response:
    Service NL agrees with this recommendation and will continue to make every possible effort to ensure that fire and life safety inspections are carried out in all regions of the province at least annually, and more often as required. It should be noted that all regions except the Central region had already been meeting this requirement. The circumstances in the Central region, in particular the staffing issues, have been reviewed and corrective action had already been undertaken in the 2014-15 fiscal year to ensure inspections are up to date.

12. ***The GSCs should ensure that technical inspectors are trained to carry out fire and life safety inspections of PCHs as required.***

    Response:
    Service NL notes that all technical inspectors who have been tasked with conducting fire and life safety inspections have received some type of training prior to assuming these inspection duties. In most cases, the training was more formalized courses and certification in the National Building Code and National fire and life safety codes, as noted in the report. In two cases, this training consisted of in-house mentoring, code familiarization and on-the-job shadowing of qualified inspectors before the inspector was allowed to conduct independent inspections. SNL acknowledges that more formalized training is a best practice and currently all existing technical inspectors who have been assigned these inspections have received formal training and either have been or are in the process of being certified. With respect to your comments on certification, we note that in the past this has covered a much broader type of inspection regime for a wide variety of facilities (e.g. hotels; office buildings; industrial facilities; and so forth) and is not a legislative requirement. As such, lapse of a certification for otherwise qualified and trained staff does not render them unqualified to perform these duties.

13. ***The GSCs should ensure that critical deficiencies identified in PCHs are corrected immediately or within the timeframe specified.***

    Response:
    SNL is in the process of reviewing and revising its inspection forms with a view to ensuring greater detail is provided. This will include consideration of a check-list approach as opposed to the current open-ended format, as well as whether terminology such as "critical" or "non-critical" are valid and appropriate definitions for deficiencies. We agree that specific timeframes for correction of deficiencies should be noted by inspectors, as and where necessary, and that best efforts are made to ensure appropriate follow-up is done.

14. ***The GSCs should provide PCHs with timeframes to correct non-critical deficiencies identified during inspections and ensure that the deficiencies are corrected within the timeframes specified.***

    Response:
    Per our comments with respect to Recommendation #13, we agree with the intent of this recommendation. We agree that specific timeframes for correction of deficiencies should be noted by inspectors, as and where necessary, and that best efforts are made to ensure appropriate follow-up is done.

15. The GSCs should consider reporting the results of inspections of PCHs to the public.

Response:
Inspection reports for individual PCHs are currently available in hard copy to the public upon request to the regional Government Service Centre responsible for each particular facility. The Department is reviewing the feasibility of posting various types of inspection results on-line. Considerations include the technology and costs that would be associated with conversion of inspection forms and/or results to an electronic format suitable for on-line posting.

16. The GSCs should conduct fire and life safety inspections and environmental health inspections at least 60 days prior to the license renewal date and recommend whether PCHs should continue to be licensed as required.

Response:
Service NL will undertake discussions with the Regional Health Authorities and the Department of Health and Community Services to review the rationale and appropriate time frames related to the conduct of the various types of inspections needed for licence renewal. This review will include a process for identification of the types of serious risks to public health or safety or persistent issues with compliance that might warrant non-renewal of a licence. However, as the final decision of whether a facility should continue to be licensed might require a more comprehensive assessment than a single inspection, barring any immediate and serious risks to safety, SNL is of the view that these decisions should be left to the licensing authority, in consultation with SNL as necessary.

PART 3.8

DEPARTMENT OF MUNICIPAL AND INTERGOVERNMENTAL AFFAIRS

MUNICIPAL INFRASTRUCTURE

Summary

Introduction

Municipal infrastructure refers to the basic structures, such as water and sewer, roads and buildings, needed to provide services to the residents and businesses in a community.

The Department of Municipal and Intergovernmental Affairs (the Department) guides infrastructure investments by:

- assessing the needs and prioritizing municipal infrastructure investments;
- providing financial support for the development of municipal infrastructure;
- monitoring and providing guidance and advice on municipal infrastructure projects;
- negotiating and managing Federal-Provincial agreements for municipal infrastructure funding;
- investing in waste management infrastructure as part of the Provincial Waste Management Strategy; and
- investing in clean and safe drinking water projects.

Objectives

The objectives of our review were to determine whether the Department:

1. has processes in place for identifying, prioritizing and monitoring municipal infrastructure needs; and
2. funds infrastructure projects in accordance with the Municipal Capital Works Program guidelines.

Scope

Our review covered the fiscal year ended March 31, 2014 and the seven-month period ended October 30, 2014. Our review included an examination of the Department's policies and procedures, financial information and files documentation, and included interviews with Department officials. We assessed the Department's grant application, assessment and approval processes and sampled 60 grant applications and 60 grant expenditures. Samples were non-statistical and were selected randomly.

We completed our review in February 2015.

Conclusions

Objective 1

The Department does not have a Provincial municipal infrastructure strategy which incorporates Provincial priorities, is linked to municipal capital planning and includes a long-term funding strategy. In addition, the Department does not have a municipal infrastructure asset management system which would capture relevant information on the inventory and the state of municipal infrastructure assets.

Objective 2

The Department has systems and processes in place for receiving, assessing and approving applications and funding for municipal infrastructure projects in accordance with the Municipal Capital Works Program guidelines, however, we identified issues with the ranking of projects.

Findings

Identifying, Prioritizing and Monitoring Municipal Infrastructure Needs

1. As at December 31, 2013, municipalities had recorded approximately $4.8 billion in tangible capital assets of which $1.9 billion, or 39%, had been amortized over the assets' useful life. Overall, municipal infrastructure assets are ageing, and significant funding will be required in the future to replace, repair or renovate these assets.

2. The Department does not have a long-term funding strategy to assist with funding allocation decisions for municipal infrastructure.

3. Based upon the current funding levels under the Municipal Capital Works Program, it would take the Department in excess of nine years to fund the current infrastructure funding requests from municipalities.

4. The Department does not require municipalities to prepare and submit municipal infrastructure plans.

5. The Department does not have a municipal infrastructure system for capturing and assessing municipal infrastructure assets.

6. The Department is not always receiving financial statements from all municipalities as required, and as such, is not compiling current information on the value of tangible capital assets. This information is not available to be used in the decision to allocate funding to municipalities.

Funding Municipal Capital Works Program Infrastructure Projects

7. For the sample of 60 applications examined, applications were assessed and approved in accordance with the Municipal Capital Works Program guidelines.

8. The project ranking system of the Department does not provide an adequate range in the ranking of projects to ensure that only priority projects are considered for funding.

9. The Department did not always document how a project's ranking was determined. 32 of the 60 applications that we examined did not have documentation to support the ranking recorded in the spreadsheet.

10. There was no direct relationship between the ranking and approval of projects. For the fiscal year ended March 31, 2015, 38 of the 84 (45%) applications approved by the Department were ranked 70 and below.

11. There was no documentation provided to support the Ministerial approval process to provide transparency for project approval.

12. For the sample of 60 grant payments examined, grant payments made were for approved projects.

Recommendations

1. The Department should consider preparing a Provincial municipal infrastructure plan which incorporates Provincial priorities, is linked to municipal capital planning, and includes a long-term funding strategy.

2. The Department should consider developing a municipal infrastructure system which captures relevant information on the inventory and state of municipal infrastructure assets in the Province.

3. The Department should consider requiring municipalities to provide an inventory of infrastructure assets and relevant information of the state of these assets in order to assess these assets.

4. The Department should improve its ranking system to identify acceptable projects that would best advance the Province's municipal infrastructure priorities.

Objectives and Scope

Objectives

The objectives of our review were to determine whether the Department of Municipal and Intergovernmental Affairs (the Department):

1. has processes in place for identifying, prioritizing and monitoring municipal infrastructure needs; and

2. funds infrastructure projects in accordance with the Municipal Capital Works Program guidelines.

Scope

Our review covered the fiscal year ended March 31, 2014 and the seven-month period ended October 30, 2014. Our review included an examination of Department policies and procedures, financial information and documentation, and included interviews with Department officials. We assessed the Department's grant application, assessment and approval processes. We reviewed a sample of 60 grant applications and 60 grant expenditures. Samples were non-statistical and were selected randomly. Our review did not include an examination of the Multi-year Municipal Capital Works Program.

We completed our review in February 2015.

Background

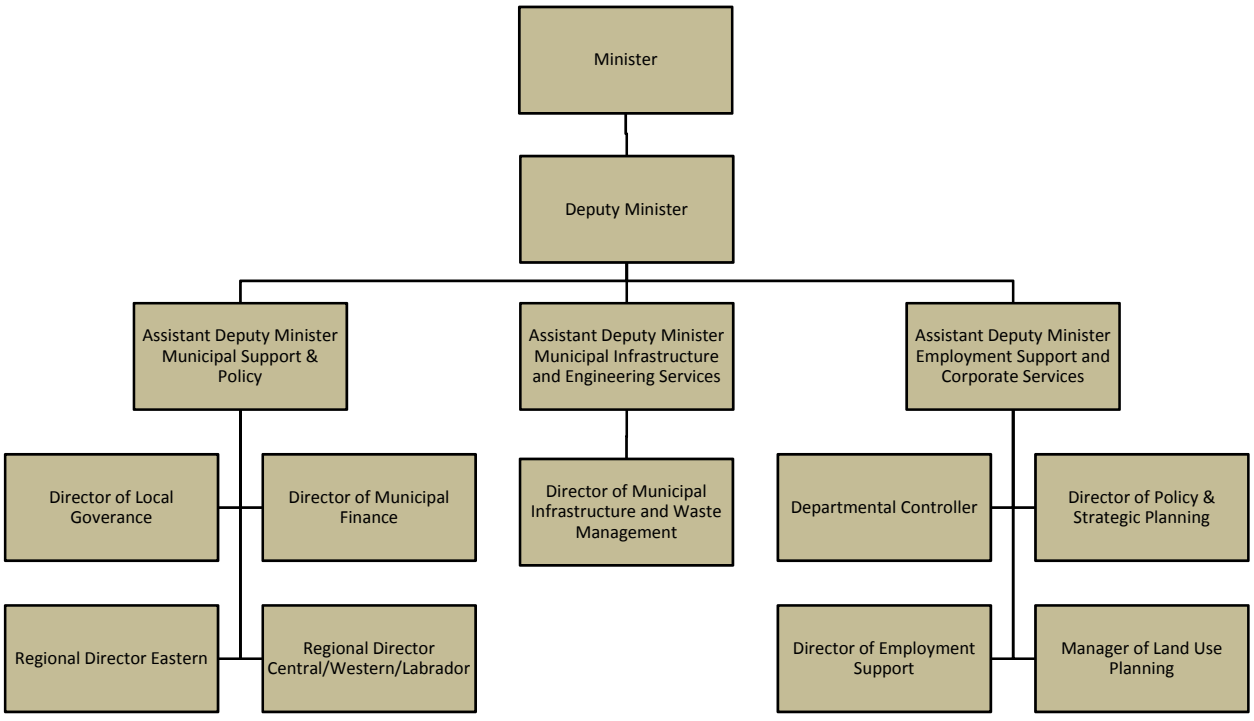
Local governments (cities, towns, local and Inuit community governments, local service districts and regional service boards) are responsible for delivering municipal services. The quality of these services impacts the lives of the people of Newfoundland and Labrador (the Province). Municipal infrastructure refers to the basic structures, such as water and sewer, roads and buildings, needed to provide services to the residents and businesses in a community.

The Department delivers its lines of business through four branches: Municipal Support and Policy, Municipal Engineering and Planning, Employment Support and Corporate Services, and Lands.

Figure 1 shows the organization of the Department.

Figure 1

Department of Municipal and Intergovernmental Affairs
Organizational Chart
March 31, 2014



Source: Department of Municipal and Intergovernmental Affairs

According to the 2014-17 Strategic Plan of the Department, the Infrastructure and Engineering Services line of business guides the funding of municipal infrastructure by:

- assessing needs and prioritizing municipal infrastructure investments;
- providing financial support to municipalities for the development of municipal infrastructure;
- monitoring and providing guidance and advice to municipalities on municipal infrastructure projects;
- negotiating and managing Federal-Provincial agreements for municipal infrastructure funding;
- investing in waste management infrastructure as part of the Provincial Waste Management Strategy; and
- investing in clean and safe drinking water projects.

Table 1 outlines the funding provided to municipalities by the Department related to municipal infrastructure for the last five years.

Table 1

Department of Municipal and Intergovernmental Affairs
Municipal Infrastructure
Grants and Subsidies
For the Years Ended March 31
($000)

Program	2011 Actual	2012 Actual	2013 Actual	2014 Actual	2015 Budget
Waste Management	$ 24,809	$ 41,958	$ 1,695	$ 12,270	
NMFC	27,497	33,334	-	-	
Recreational Infrastructure Program	-	-	2,369	14,802	
Municipal Capital Works Program	28,618	26,172	31,670	26,377	
Multi-year Municipal Capital Works Program	7,487	8,306	20,509	35,953	
Total Provincial Municipal Infrastructure	**88,441**	**109,770**	**56,243**	**89,402**	**$115,309**
Federal/Provincial Infrastructure Programs	85,415	76,172	23,569	31,838	29,308
Canada/Newfoundland and Labrador Gas Tax Program	28,712	15,282	23,834	22,798	41,415
Total Municipal Infrastructure Grants and Subsidies	**$202,538**	**$201,224**	**$103,646**	**$144,038**	**$186,032**
Less: Federal Funding					
Federal/Provincial Infrastructure Programs	33,402	30,678	8,403	4,603	12,000
Canada/Newfoundland and Labrador Gas Tax Program	31,166	31,166	31,166	31,166	41,873
Provincial Funding	**$137,970**	**$139,380**	**$ 64,077**	**$108,269**	**$132,159**

Source: Reports on the Program Expenditures and Revenues of the Consolidated Revenue Fund and 2014 Estimates

During the fiscal years 2011 to 2015, the Province allocated $581.9 million in infrastructure funding to municipalities. Given the level of funding provided to municipalities for investment in infrastructure, it is important that the Department has the necessary processes and systems in place for ensuring funding is allocated in a manner that recognizes province wide priorities.

Detailed Observations

1. Identifying, Prioritizing and Monitoring Municipal Infrastructure Needs

Objective

To determine whether the Department has processes in place for identifying, prioritizing and monitoring municipal infrastructure needs.

Conclusion

The Department does not have a Provincial municipal infrastructure strategy which incorporates Provincial priorities, is linked to municipal capital planning and includes a long-term funding strategy. In addition, the Department does not have a municipal infrastructure asset management system which would capture relevant information on the inventory and the state of municipal infrastructure assets.

Our review considered whether:

- The Department has a process for identifying, evaluating and managing infrastructure needs for each municipality;
- The Department considers municipal long-term capital plans, if prepared, when identifying and prioritizing municipal capital projects;
- The Department has systems and processes in place, which captures information on municipal infrastructure assets, and is used to assess and monitor the status of the assets; and
- Audited financial statements for municipalities are submitted to the Department and financial information on tangible capital assets is compiled and assessed.

Overview

Municipalities throughout the Province are facing a variety of infrastructure challenges. New and evolving environmental standards in areas such as wastewater and water quality place significant demands on municipal infrastructure. Climate change and more extreme weather events, such as hurricanes, rising sea levels and coastal erosion, are also creating infrastructure problems for many communities. Adding to these challenges are shifting population trends as well as increasing infrastructure costs. These challenges place pressure on both the financial and human resource capacity of communities.

Over the last five years, the Province has provided an average of $116 million annually to assist municipalities with their infrastructure requirements. Given the significant expenditures made annually on municipal infrastructure, we would expect the Department would have a process in place to ensure the best possible decisions regarding the building, operating, maintaining, renewing, replacing and disposing of infrastructure assets are made. A Provincial strategy would maximize benefits, manage risk, and provide satisfactory levels of service to the public in a sustainable manner.

Cost and Amortization of Tangible Capital Assets

The financial statements of municipalities provide disclosure on the cost and amortization of tangible capital assets by category. Table 2 provides an estimate of tangible capital assets of 260 municipalities in the Province as at December 31, 2013. Because of incomplete data for some municipalities for 2013, our analysis used data provided in the 2012 financial statements for 32 municipalities. We excluded information for 16 municipalities because there were no 2013 or 2012 financial statements filed with the Department.

Table 2

Department of Municipal and Intergovernmental Affairs
Net Book Value of Municipal Infrastructure
As at December 31, 2013

Asset Class	Book Value	Amortization	Net Value	Percent Amortized
Land and improvements	$ 164,517,040	$ 30,137,393	$ 134,379,647	18%
Buildings	809,782,443	277,819,826	531,962,617	34%
Vehicles	392,352,376	200,672,394	191,679,982	51%
Computer hardware and software	4,807,900	2,338,071	2,469,829	49%
Roads, streets and bridges	1,704,362,748	728,729,825	975,632,923	43%
Water and sewer	1,444,425,431	641,243,949	803,181,482	44%
Assets under construction	263,412,425	223,570	263,188,855	0%
Total	**$4,783,660,363**	**$1,881,165,028**	**$2,902,495,335**	**39%**

Source: Department of Municipal and Intergovernmental Affairs database

As Table 2 indicates, municipalities recorded approximately $4.8 billion in tangible capital assets of which 39%, or $1.9 billion, had been amortized over the assets' useful life.

A further review of the 260 municipalities' information indicated that a number of municipalities had significant amortized assets. For example, 39 of the 260 municipalities had their tangible capital assets amortized more than 70%. Ninety-three municipalities had their roads, streets and bridges amortized 70% or more, 88 municipalities had their buildings and improvements amortized 70% or more and 36 municipalities had their water and sewer assets amortized 70% or more.

Although the net book value of assets in itself is limited in assessing the status of municipal infrastructure in the Province, it does indicate that, overall, municipal infrastructure assets are ageing, and significant funding will be required in the future to replace, repair or renovate these assets.

Finding

1. As at December 31, 2013, municipalities had recorded approximately $4.8 billion in tangible capital assets of which $1.9 billion, or 39%, had been amortized over the assets' useful life. Overall, municipal infrastructure assets are ageing, and significant funding will be required in the future to replace, repair or renovate these assets.

Funding Strategy

The Department does not have a Provincial municipal infrastructure plan in place, does not require municipalities to submit infrastructure plans to the Department, and does not have a Provincial infrastructure management system for recording and monitoring information on the inventory and state of municipal infrastructure assets. The Department does receive annual audited financial statements from municipalities, but information compiled on tangible capital assets is of limited use for identifying, prioritizing and monitoring municipal infrastructure needs.

Sound financial decisions and developing an effective long-term funding strategy are critical to the implementation of the Provincial municipal infrastructure program. Knowing the full economic costs, revenues and risks generated by municipal infrastructure would enable the Department to develop an infrastructure financial forecast over the next 10 to 15 years. A financial forecast can then help the Department decide what changes need to be made to its infrastructure's long-term funding strategy as well as what risks to accept or transfer to the municipalities.

The funding strategy of the Department is limited to its annual budget and is constrained by the construction capacity of the municipalities.

With the exception of the three-year multi-year funding provided under the municipal capital works program to larger municipalities, funding of municipal infrastructure is provided through an annual application process. For the 2013-14 fiscal year, the Department received 374 applications for funding totaling $200.0 million, of which 136 applications were approved totaling $20.9 million. Based upon this approval rate, and assuming all applications for funding were priority projects submitted by municipalities, it would take the Department in excess of nine years to fund the current infrastructure needs. In the absence of a funding strategy, the Department is not adequately prioritizing the infrastructure needs of each community within its fiscal constraints.

Findings

2. The Department does not have a long-term funding strategy to assist with funding allocation decisions for municipal infrastructure.

3. Based upon the current funding levels under the Municipal Capital Works Program, it would take the Department in excess of nine years to fund the current infrastructure funding requests from municipalities.

Municipal Capital Plans

A Provincial municipal infrastructure plan should encompass the priorities and plans established by each municipality. Information provided on a municipality's future infrastructure needs, including the actual inventory, location, physical condition, remaining service life and replacement costs of municipal assets would assist the Department in developing its own municipal infrastructure plan and priorities.

Our review identified that the Department does not require municipalities to prepare and submit municipal infrastructure plans to the Department for review. As a result, the Department does not know which municipalities have infrastructure plans in place or whether any infrastructure plans could be used to support Department priorities.

Finding

4. The Department does not require municipalities to prepare and submit municipal infrastructure plans.

Municipal Infrastructure System

Our review identified that the Department does not have a municipal infrastructure system. In 2008, the Department provided funding to the Town of Marystown and the City of Mount Pearl to test and implement two asset management systems. In 2011, the Province retained an external consultant to evaluate these systems in the following areas:

- the suitability of the systems for use by municipalities in the Province;

- develop a conceptual view of what a Province wide implementation plan would look like, including the costs for each option; and

- make a recommendation as to the most practical approach based on industry knowledge.

The consultant determined that the costs associated with the implementation of the recommended system would be in excess of $10.3 million, excluding annual operating costs of the Department and municipalities. The Department indicated that it did not proceed with the project as it was cost prohibitive to implement and that most municipalities did not have the technical or financial capacity to implement and maintain such a system.

Finding

5. The Department does not have a municipal infrastructure system for capturing and assessing municipal infrastructure assets.

Annual Financial Reporting

The Department requires municipalities to submit annual audited financial statements to the Department by June 30. The Department compiles the financial statement information in its Municipal Information Management System (MIMS). Our review of the municipal financial information for the year ended December 31, 2013 disclosed the following:

- The Department's MIMS was not being kept up to date. The Department had not updated its municipal financial statement spreadsheet at the time of our original request on November 21, 2014. The Department subsequently updated MIMS and provided us with an updated database on December 15, 2014.

- As at December 11, 2014, 228 of the 276 (83%) municipalities in the Province had submitted their financial statements for the year ended December 31, 2013. Significant absences included the City of St. John's, the Town of Happy Valley - Goose Bay and the Town of Labrador City.

Delays in receiving financial statements and not updating the spreadsheet promptly, diminishes the usefulness of this information.

Finding

6. The Department is not always receiving financial statements from all municipalities as required, and as such, is not compiling current information on the value of tangible capital assets. This information is not available to be used in the decision to allocate funding to municipalities.

2. Funding Municipal Capital Works Program Infrastructure Projects

Objective

To determine whether the Department funds infrastructure projects in accordance with the Municipal Capital Works Program guidelines.

Conclusion

The Department has systems and processes in place for receiving, assessing and approving applications and funding for municipal infrastructure projects in accordance with the Municipal Capital Works Program guidelines, however, we identified issues with the ranking of projects.

Our review considered whether:

- The Department maintains a system, which records information on applications received, approved and funded;
- Applications are submitted in accordance within Program guidelines;
- Applications are assessed in accordance with the ranking system of the Department;
- The Department funds municipal infrastructure projects based on its ranking system and approved budget allocations;
- The Department assesses the ability of the municipality to meet its share of the cost and whether a Financial Evaluation form is completed; and
- Municipalities are notified of rejected applications and reasons for decision.

Overview

For the fiscal year ended March 31, 2014 and the 7-month period ending October 31, 2014, the Department received 708 applications for funding requests totaling $425.8 million, and approved 235 applications totaling $51.0 million. These amounts do not include funding under the multi-year funding program provided to larger municipalities. Table 3 provides a summary of applications received, approved and funded by infrastructure category.

Table 3

Department of Municipal and Intergovernmental Affairs
Municipal Infrastructure
Summary of Municipal Capital Works Program
($ Millions)

Infrastructure Project	For the Year Ended March 31, 2014				For the 7 Months Ended October 31, 2014			
	Applications submitted		Applications approved		Applications submitted		Applications approved	
	#	$	#	$	#	$	#	$
Water and sewer	197	130.1	81	13.2	171	134.0	65	19.8
Roads and bridges	135	54.1	31	5.2	96	48.1	25	5.8
Buildings	20	10.8	11	1.0	40	24.0	7	4.3
Recreation	16	3.7	9	1.2	16	15.5	-	-
Other	6	1.3	4	0.3	11	4.2	2	0.2
Total Projects	**374**	**200.0**	**136**	**20.9**	**334**	**225.8**	**99**	**30.1**

Source: Department of Municipal and Intergovernmental Affairs
Note 1: Information does not cover applications approved in prior years and carried forward.

Under the Municipal Capital Works Program, municipalities submit applications annually for capital projects, which the municipalities have assessed as priority projects. The Department assesses the projects and rates them in accordance with its ranking system. Rated projects are then reviewed and considered for approval within approved budget allocations. The Department monitors the progress of projects and advances funds based on project billing or cash flow projections. The Department makes the final project payment based on the actual costs indicated on the status report and job control sheet.

The Municipal Capital Works Program is application driven, with applications being submitted to the Department by municipalities or local service districts through the Municipal Support Information System (MSIS). The Department developed MSIS in order to manage a project from application to completion. MSIS was also linked to the Government financial management system (FMS) for payment purposes and to provide support for the program funding commitments. MSIS came on line in December 2013 in time to manage the 2014-15 fiscal year grant process.

Assessment and Approval of Grant Applications

Introduction

The Department has established guidelines for the assessment and approval of grant applications submitted by municipalities. The application process is as follows:

- Municipalities submit applications and required supporting documentation electronically using the MSIS.

- Regional office staff review the applications for eligibility.

- Each region has a team that ranks the individual projects. These teams consist of staff from the regional office, the Department of the Environment and Conservation, the Department of Health and Community Services and Service NL.

- Department staff lists the applications on an electronic spreadsheet, which is reviewed by the Director of Municipal Infrastructure and Waste Management, the Assistant Deputy Minister of Municipal Infrastructure and Engineering Services and the Deputy Minister of Municipal and Intergovernmental Affairs for quality, accuracy and the ability of the municipality to complete the project within three years.

- In accordance with a Cabinet Directive issued in 2008, the Minister of Municipal and Intergovernmental Affairs consults with his colleagues and other members of the House of Assembly to determine which projects to approve.

Compliance with Program Guidelines

We selected a sample of 60 applications, 30 for the 2013-14 fiscal year and 30 for the 2014-15 fiscal year, to determine if the Department was following its guidelines in processing the Municipal Capital Works Program applications. Of the applications that we examined, 17 applications were approved, 39 were rejected and 4 were withdrawn. Our review found that applications were assessed and approved in accordance with the Municipal Capital Works Program guidelines.

Finding

7. For the sample of 60 applications examined, applications were assessed and approved in accordance with the Municipal Capital Works Program guidelines.

Ranking System

The Department uses “Ranking Guidelines and Ranking Codes - Ranking Book” (the Ranking Book) to determine and document the merits of project applications under the Municipal Capital Works Program. Rankings are provided based upon the type of project and are grouped into two categories: health, safety environment or need and density. The Ranking Book details the points to be assigned for each category. Points assigned under both categories are then added to determine the total ranking for each project – 100 being the highest ranking. Table 4 summarizes the rankings by type of project and the range of points by category.

Table 4

Department of Municipal and Intergovernmental Affairs
Municipal Infrastructure
Municipal Capital Works Ranking Codes

Type of Project	Health, Safety, Environment or Need		Density	
	Bases	Points Range	Bases	Points Range
A. Water supply quality	Health	0 – 50	Metres of road per house	0 – 50
B. Water supply quantity	Health	0 – 50	Metres of road per house	0 – 50
C. Sewage disposal systems	Health	0 – 50	Metres of road per house	0 – 50
D. Basic infrastructure	Need	0 – 50	Percent of population	0 – 50
E. Road upgrading and paving	Safety	0 – 50	Type of road and usage	0 – 50
F. Municipal buildings	Need	25 – 50	Population	25 – 50
G. Recreation and sport	Need	25 – 50	Population	8 – 50
H. Water treatment	Health	0 – 100		
I. Wastewater treatment	Environment	10 – 50	Environmental Impact	10 – 50

Source: *Municipal Capital Works Project Ranking Guidelines and Ranking Codes*

The ranking of projects is a time-consuming process and involves a number of employees at different levels. Therefore, ensuring that the ranking system provides good value to the assessment process is important. Our review of the ranking system identified a number of limitations with the process:

- The Department did not establish a minimum ranking threshold so that projects that were below a minimum ranking threshold would be screened out from further assessment. As a result, projects that were ranked low continued to be considered for funding.

- The ranking process results in a number of projects being ranked with the same ranking. For example, for the 2014-15 fiscal year, there were 56 projects ranked at 100 points, the maximum ranking. As a result, the process is limited in assisting the Department with prioritizing projects.

- The Department did not always document how a project's ranking was determined. Our review identified that some staff used a ranking sheet to document their analysis, however, the Department indicated that this was not a requirement. We noted that 32 of the 60 applications that we examined did not have documentation to support the ranking recorded in the spreadsheet.

- As Table 4 indicates, the minimum points vary between each type of project which results in rankings being skewed when comparing the merits of different types of projects. For example, the lowest ranking for municipal building and recreation projects is 50 points, when compared to 0 for water and sewer projects. Although the Department indicated that the ranking system is not specifically used for comparing one project against another project, ranking scales should be consistent for comparison between project types.

Findings

8. The project ranking system of the Department does not provide an adequate range in the ranking of projects to ensure that only priority projects are considered for funding.

9. The Department did not always document how a project's ranking was determined. 32 of the 60 applications that we examined did not have documentation to support the ranking recorded in the spreadsheet.

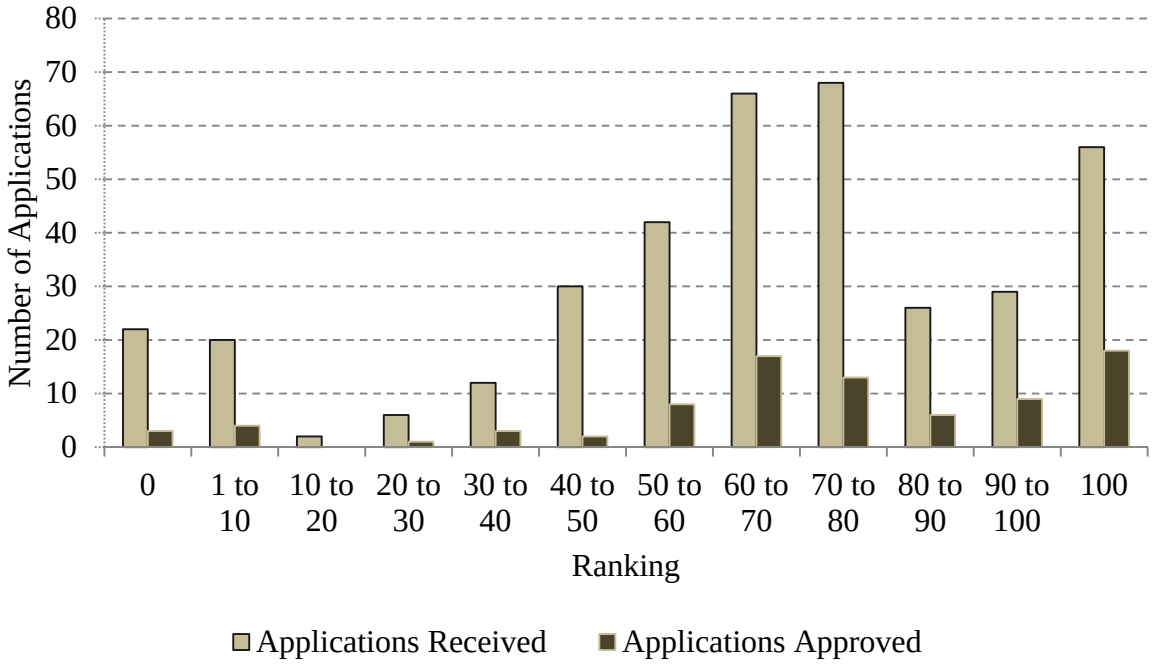
Application Ranking and Approvals

The ranking of a project is one of many factors that the Department uses to determine whether a project should be approved. Other factors include the availability of funding, the equitable distribution of funding, the number and value of uncompleted projects previously approved, the ability of the municipality to finance its share of the cost and the operating cost of the asset once it is completed.

Our review included an analysis of the rankings to determine what effect the rankings had in the approval process. Figure 2 shows the approval level of the 2014-15 applications by rank.

Figure 2

Department of Municipal and Intergovernmental Affairs
Municipal Infrastructure
Ranking of Applications Received and Approved
For the Year Ending March 31, 2015



Source: Department of Municipal and Intergovernmental Affairs database

As Figure 2 shows, there was no direct relationship between the ranking and approval of projects. We expected to see a positive correlation between the approval of projects and higher ranked projects. However, the Department appears to be approving projects without consideration as to ranking, as evidenced by the number of projects approved with low rankings. For example, 38 of the 84 (45%) approved applications for the year ended March 31, 2015 were ranked at 70 and below.

Finding

10. There was no direct relationship between the ranking and approval of projects. For the fiscal year ended March 31, 2015, 38 of the 84 (45%) applications approved by the Department were ranked 70 and below.

Ministerial Approval Process

Once the Department executive has reviewed the applications, a listing is presented for the Minister. Through consultations with colleagues and other members of the House of Assembly, Department staff and municipalities, the Minister approves projects for the year.

There was no documentation provided to support the Ministerial approval process to provide transparency for project approval.

Finding

11. There was no documentation provided to support the Ministerial approval process to provide transparency for project approval.

Payments

We reviewed a random sample of 60 payments for the period April 1, 2013 to October 31, 2014 under the Municipal Capital Works Program to determine if the Department was making grant payments only for approved projects. Our review identified that grant payments were for approved projects.

Finding

12. For the sample of 60 grant payments examined, grant payments made were for approved projects.

Recommendations

1. The Department should consider preparing a Provincial municipal infrastructure plan which incorporates Provincial priorities, is linked to municipal capital planning, and includes a long-term funding strategy.

2. The Department should consider developing a municipal infrastructure system which captures relevant information on the inventory and state of municipal infrastructure assets in the Province.

3. The Department should consider requiring municipalities to provide an inventory of infrastructure assets and relevant information of the state of these assets in order to assess these assets.

4. The Department should improve its ranking system to identify acceptable projects that would best advance the Province's municipal infrastructure priorities.

Department Response

Recommendation #1

The Department should consider preparing a Provincial municipal infrastructure plan which incorporates Provincial priorities, is linked to municipal capital planning, and includes a long-term funding strategy.

Department's Response:

The Department acknowledges that a long term municipal infrastructure plan would be the optimal tool to inform future investment. However, municipal infrastructure planning is driven by the decisions of local governments who apply to the province for cost shared funding. We also acknowledge that municipal infrastructure is aging, even with the significant investments in municipal infrastructure since 2008 that have averaged in excess of $115M annually.

Since municipalities own and maintain their municipal infrastructure (not the Department), information gaps exist related to the inventory and condition of the assets that would assist in the development of a long term capital plan for municipal infrastructure investment. Acknowledging this, the department began to explore the options associated with the implementation of a province wide municipal infrastructure asset management system in 2010 and retained Prior and Prior to conduct a feasibility assessment and to provide recommendations related to an asset management system. However, given the significant cost such a system would impose on municipalities, the Department chose not to proceed with the development of an asset management system at the time.

Although the Department did not have asset information from a modern asset management system, it did in 2014 undertake significant analysis to assess municipal infrastructure capital investment needs over the next ten years. The analysis considered the depreciated value of current municipal infrastructure assets, the participation level of municipalities in calls for municipal infrastructure applications and, the demonstrated capacity of the engineering consulting and construction sectors in undertaking work arising from the Department's infrastructure programs. This analysis also considered provincial priorities such as improving drinking water, water treatment and waste water treatment infrastructure for communities. We will continue to undertake comprehensive analysis and planning to guide future investments, while being mindful of the province's fiscal circumstances.

Recommendation #2

The Department should consider developing a municipal infrastructure system which captures relevant information on the inventory and state of municipal infrastructure assets in the Province.

Department's Response:

There are 276 Municipalities and Inuit Community Governments in the province, with populations ranging from 5 to over 106,000 residents. There is a wide range in the type of services required and delivered, and the infrastructure requirements to deliver those services vary. As such, the need for and type of asset management approach will vary. The development of an appropriate framework for asset management must consider these differences and must reflect the different asset management requirements of each municipality in a way that also promotes consistency and good asset management practices, while considering the circumstances and the capacity of individual municipalities.

Under the recently signed Federal/Provincial Agreement, the Federal Gas Tax Program requires the implementation of improved asset management practices for municipalities who receive gas tax funding. The Department has submitted an Asset Management proposal to Infrastructure Canada under the Canada-NL Gas Tax Administration Agreement to develop a framework for a province wide municipal infrastructure asset management system. Approval of this proposal will assist the Department to assess the current municipal asset management practices in the province, update the previously completed jurisdictional scan of best practices in North America and develop, in conjunction with municipalities, a municipal infrastructure asset management framework to guide the development of a modern province wide asset management system.

Recommendation #3

The Department should consider requiring municipalities to provide an inventory of infrastructure assets and relevant information of the state of these assets in order to assess these assets.

Department's Response:

The Department currently requires municipalities to submit an inventory of tangible capital asset information in accordance with Public Sector Accounting Board (PSAB) Standards as part of their annual audited financial statement submission that is required by June 30th of each year. As an incentive to ensure the financial statements are received, the department will typically retain future Municipal Operating Grants due to the municipality until the financial statement(s) is received.

It is acknowledged that the infrastructure inventory information included in the audited financial statements does not provide specific information related to the state or condition of individual assets, other than to show the depreciated value of the asset. Maintaining a current inventory of infrastructure assets and associated condition assessment is an integral part of a modern day Asset Management System which the department has been exploring since 2010 and as referenced in the Department's response to recommendation #2 above. As asset management practices are implemented by municipalities, the Department will consider adding a requirement for the submission of asset inventory and condition assessments to the Department on an annual basis, as part of its ongoing efforts to ensure appropriate municipal accountability.

Recommendation #4

The Department should improve its ranking system to identify acceptable projects that would best advance the Province's municipal infrastructure priorities.

Department's Response:

The Department is open to reviewing its current ranking criteria and process to explore possible improvements to our review of municipal infrastructure project applications.

However, it is important to understand that the initial numerical ranking of proposed projects is only one component of the overall evaluation process. As acknowledged in your report, there are many factors used to determine whether a project is approved for funding. Other factors include: the availability of funding; the distribution of funding across municipalities and Local Service Districts; the number and value of uncompleted projects a community currently has ongoing; the ability of the municipality to finance its share of the capital cost; and the additional annual operating cost the community will be responsible for with the completion of the project.

In addition to the factors identified above, the Department has also begun assessing whether or not a community has drinking water quality issues. With improving drinking water quality as one of the highest priorities for the province, the department may not consider other categories of infrastructure projects (e.g. Street improvements) as a high priority for approval while a municipalities drinking water quality issue goes unaddressed. A similar consideration may be applied to waste water treatment projects as more information become available related to the level of municipal wastewater treatment compliance associated with new federal waste water regulation that came into effect in 2012.

PART 3.9

SERVICE NL

PENSION PLAN REGULATION

Summary

Introduction

The Pension Benefit Standards Division (the Division) of Service NL (the Department) was established during 2010-11. The Division is responsible for the administration and enforcement of the legislation that governs employer-sponsored pension plans established in respect of Newfoundland and Labrador employees. The applicable legislation is as follows:

- *Pension Benefits Act, 1997* (the *Act)*;
- *Pension Benefits Act Regulations* (the *Regulations); and*
- *Solvency Funding Relief Regulations* (the *Relief Regulations*).

There are generally three types of pension plans registered with the Division:

1. Defined benefit (DB) plans are structured so that the pension to be received by the member at retirement is based on a pension formula that is defined in the plan documents;
2. Defined contribution (DC) plans have specific employee and employer contribution requirements (usually based on salary or a combination of salary and service); and
3. Combination plans are plans that have a combination of DB and DC provisions.

As at March 31, 2014, there were 220 pension plans registered with the Province, 101 DB plans, 111 DC plans and 8 combination plans which represented 75,383 active plan members and had a total market value of plan assets of $10.32 billion.

Objective

The objective of our review was to determine whether pension plans registered with the Province of Newfoundland and Labrador were monitored to ensure compliance with legislation.

Scope

Our review covered the period April 1, 2011 to March 31, 2014. It included interviews with the Department officials and an examination of applicable legislation, internally developed policies and procedures and database information. It also included detailed testing of the documentation maintained by the Department for a sample of pension plan files. The samples selected for our review were determined non-statistically, on a random and judgmental basis.

We completed our review in February 2015.

Conclusion

For the sample of pension plans selected, the Division did not always conduct adequate monitoring to ensure compliance with legislation during the period of our review.

Findings

Registrations and Amendments

1. Two of the 19 pension plans registered during the period of our review were registered on the condition that the plan text would be amended. However, the required revisions were not made and as a result these pension plans have been operating for periods of approximately 38 and 33 months respectively, while not in full compliance with legislation.

2. The documentation used to support the registration of one of the 19 pension plans that had been registered during the period of our review had two different effective dates for the start of the plan. The effective date impacts when benefits start accruing to plan members.

3. The registration process for the 19 pension plans that had been registered during the period of our review was not always being completed in a timely manner. The average length of time required to complete the registration process was 222 days, ranging from a low of 17 days to a high of 685 days. As a result, instances of non-compliance may have gone undetected for extended periods of time reducing the opportunity for intervention and/or corrective action which may have put plan members at risk.

4. Required documentation for pension plan amendments was not always submitted to the Superintendent of Pensions. Documentation for two of the 36 plan amendments occurring during the period of our review had not been submitted.

5. Nine of the 34 amendments examined were not registered with the Department within 60 days of the amendment date as required. The average length of time the application for registration of the amendments was late was 185 days, ranging from a low of one day to a high of 487 days.

6. Based on our examination of 34 amendments which occurred during the period of our review, there was no evidence that the Department communicated with the pension plans who had not registered amendments within the required 60 days of the amendment date.

7. Pension plan amendments were not being reviewed by the Department in a timely manner. Of the 34 amendments examined we found that seven had not been reviewed by the Department. For the 27 amendment reviews completed by the Department, the average length of time required to complete a review was 296 days, ranging from a low of one day to a high of 1,029 days. As a result, instances of non-compliance may have gone undetected for extended periods of time reducing the opportunity for intervention and/or corrective action which may have put plan members at risk.

Reporting Requirements

8. Not all Annual Information Returns (AIRs) were being submitted to the Department within six months of the end of the fiscal year as required by legislation. During the period of our review, we examined a sample of 100 AIRs that were required to be filed. We found that:

    - One pension plan had not filed AIRs for the two most recent year-ends, January 31, 2014 and January 31, 2013 until January 26, 2015.

    - 36 of the remaining AIRs sampled were not in compliance with legislation as plan administrators had not filed the AIRs within six months of the end of the fiscal year as required. The average length of time the AIRs were submitted late was 14 days, ranging from a low of one day to a high of 95 days.

    - A late fee was imposed in only two instances.

    - Although the Division communicated with the plan administrators who filed AIRs late, the communication of non-compliance was not consistently documented.

9. AIRs were not always being reviewed by the Department in a timely manner. At the time of our review, we found that:

    - Of the 68 AIRs that had reviews completed, the average length of time taken to complete a review was 163 days, ranging from a low of six days to a high of 510 days. As a result, instances of non-compliance may have gone undetected for extended periods of time. In addition, the extended period of time required for review may limit the opportunity for intervention and/or corrective action which may have put plan members at risk.

    - 30 of the AIRs from our sample had not yet been fully reviewed. These 30 AIR reviews were at various stages of completion. The average length of time the review of these returns remained outstanding was 283 days ranging from a high of 808 days to a low of 34 days.

10. Actuarial valuations were not always filed with the Superintendent of Pensions within nine months of the review date, as required by legislation. Three of our sample of 17 defined benefit pension plans had not filed within nine months of the review date. The average length of time the actuarial valuations were submitted late was 146 days, ranging from a low of 23 days to a high of 387 days.

11. Based on our review of our sample of 17 defined benefit pension plans, for the three plans that were late in submitting the actuarial valuation, the Department communicated the non-compliance in all three instances.

12. Actuarial valuations were not always being reviewed by Division officials in a timely manner. For the 17 defined benefit pension plans we reviewed, we found that three actuarial valuation reviews had not yet been completed. The average length of time these reviews were outstanding was 409 days, ranging from a low of 113 days to a high of 1,000 days. As a result, instances of non-compliance may have gone undetected for extended periods of time. In addition, the extended period of time required for review may limit the opportunity for intervention and/or corrective action which may have put plan members at risk.

Surplus Payments and Transfers of Plan Assets

13. All three pension plans that had transfers of plan assets during the period of our review were completed in accordance with legislation.

Plan Terminations

14. Plan terminations were not always in compliance with legislation. We found that two of the 14 pension plans that were terminated during the period of our review had not submitted their annual information returns within three months of the effective date of termination as required.

Solvency Funding Relief

15. Pension plans which availed of the Solvency Funding Relief provided by the Province were not always in compliance with legislation. Two of the four pension plans reviewed for compliance with solvency funding relief requirements had not submitted their actuarial valuations within nine months of the plan year end as required.

Inspections and Audits of Pension Plans

16. Although the *Pension Benefits Act* gives the Superintendent of Pensions the authority to conduct inspections and audits of pension plans registered with the Province, none have been completed.

Recommendations

1. The Department should communicate instances of non-compliance to pension plan administrators on a timely basis.

2. The Department should consider implementing a policy for imposing penalties in instances of non-compliance.

3. The Department should implement processes that would enable them to complete reviews of registrations, amendments, annual information returns and actuarial valuations, in a timely manner.

4. The Department should investigate the development of a policy for identifying and performing external inspections/audits of pension plans registered with the Province.

Objective and Scope

Objective

The objective of our review was to determine whether pension plans registered with the Province of Newfoundland and Labrador were monitored to ensure compliance with legislation.

Scope

Our review covered the period April 1, 2011 to March 31, 2014. It included interviews with Service NL (the Department) officials and an examination of applicable legislation, internally developed policies and procedures and database information. It also included detailed testing of the documentation maintained by the Department for a sample of pension plan files. The samples selected for our review were determined non-statistically, on a random and judgmental basis.

We completed our review in February 2015.

Background

The Pension Benefit Standards Division (the Division) of the Department was established during 2010-11. The Division is responsible for the administration and enforcement of the legislation that governs employer-sponsored pension plans established in respect of Newfoundland and Labrador employees. The applicable legislation is as follows:

- *Pension Benefits Act, 1997* (the *Act)*;
- *Pension Benefits Act Regulations* (the *Regulations); and*
- *Solvency Funding Relief Regulations* (the *Relief Regulations*).

There are generally three types of pension plans registered with the Division:

1. Defined benefit (DB) plans are structured so that the pension to be received by the member at retirement is based on a pension formula that is defined in the plan documents. Generally, the pension formula is based on a combination of years of service and pensionable salary. The employer promises a pension income payable for the life of the employee (continuing to a surviving principal beneficiary if applicable) and the benefit is funded by employer and often employee contributions over the course of the employees' employment. Valuations are performed at least every three years by an actuary to determine if the accumulated assets are sufficient to cover the obligations of the plan or if increased funding is necessary. Usually, any additional funding is the sole responsibility of the employer.

2. Defined contribution (DC) plans have specific employee and employer contribution requirements (usually based on salary or a combination of salary and service). The contributions accumulate over the employees' course of employment and at retirement are transferred from the pension plan into an approved retirement savings arrangement to provide the employee with income for the remainder of their life (continuing to a surviving principal beneficiary if applicable). The actual pension income that can be provided is not known with certainty in advance and depends on contributions, investment earnings and life annuity rates at the time of retirement.

3. Combination plans are plans that have a combination of DB and DC provisions. It may be that different employees fall under DB or DC provisions within the plan, or the plan may have past service DB provisions with DC provisions for future service only, or the benefit accrued by plan members each year may be a blend of DB and DC benefits.

Table 1 summarizes the number of DB plans, DC plans and combination plans registered with the Division for the years ended March 31, 2012 to March 31, 2014.

Table 1

Service NL
Pension Administration
Summary of Registered Pension Plans
For the Years Ended March 31

Year	Defined Benefit	Defined Contribution	Combination	Total
2012	100	110	8	218
2013	100	112	8	220
2014	101	111	8	220

Source: Service NL, Pension Benefit Standards Division

Table 2 shows the total number of active plan members and the total market value of the pension plan assets for the registered DB plans, DC plans and combination plans for the same time frame.

Table 2

Service NL
Pension Administration
Active Plan Members and Market Value of Plan Assets
For the Years Ended March 31

Year	Defined Benefit		Defined Contribution		Combination		Total	
	# of Active Plan Members	Market value of Plan Assets (billions)	# of Active Plan Members	Market value of Plan Assets (billions)	# of Active Plan Members	Market value of Plan Assets (billions)	# of Active Plan Members	Market value of Plan Assets (billions)
2012	48,326	$8.27	19,887	$0.49	5,171	$1.12	73,384	$9.88
2013	49,325	$7.92	19,563	$0.51	5,726	$1.10	74,614	$9.53
2014	49,869	$8.59	19,256	$0.54	6,258	$1.19	75,383	$10.32

Source: Service NL, Pension Benefit Standards Division

Detailed Observations

Monitoring of Pension Plan Compliance with Legislation

Objective

The objective of our review was to determine whether pension plans registered with the Province were monitored to ensure compliance with legislation.

Conclusion

For the sample of pension plans selected, the Division did not always conduct adequate monitoring to ensure compliance with legislation during the period of our review.

Overview

The mandate of the Division and the objectives of the legislation are to protect the accrued pension entitlements of plan members to the extent possible, and to ensure the equitable treatment of plan members. Legislation requires pension plans to comply with the minimum benefit requirements and the minimum funding standards and the regular monitoring and review of all plan documents, actuarial valuations and annual information return forms.

The Superintendent of Pensions (the Superintendent) is responsible for the administration and enforcement of the *Act*, the development and interpretation of pension legislation and issuance of policies and guidelines.

We reviewed the documentation pertaining to a sample of pension plans registered with the Province and identified findings in the following areas:

- Registrations and Amendments
- Reporting Requirements
- Surplus Payments and Transfers of Plan Assets
- Plan Terminations
- Solvency Funding Relief
- Inspections and Audits of Pension Plans

Registrations and Amendments

Introduction

The *Act* states that, *"An administrator of a pension plan applying for registration of the plan, or an amendment to the plan, shall do so as required by the superintendent and shall provide the information required by the superintendent."*

Our review of the registration and the amendment of pension plans identified the following:

Registrations

Before a pension plan is registered, the Division will conduct an assessment of the plan documentation to ensure compliance with all requirements of the *Act*. The *Act* and corresponding directives set out the requirements for pension plan registration. The *Act* states that, *"A pension plan is not eligible for registration unless:*

a) it provides for the accrual of pension benefits in a gradual and uniform manner; and

b) the formula for computation of the employer's contributions to the pension fund or the pension benefit provided under the plan is not variable at the discretion of the employer."

It also states that, *"A pension plan that contains a defined contribution provision is not eligible for registration if the formula governing allocation of contributions to the pension fund among members of the plan is variable at the discretion of the employer".*

Policy Directive No. 1 - Registration Requirements issued by the Division state that administrators of pension plans are required to register pension plans within 60 days of the establishment of the plan. It also sets out information requirements to be submitted to the Superintendent upon registration.

We reviewed all 19 pension plans that had been registered with the Division during the period April 1, 2011 to March 31, 2014. We determined that two of the 19 pension plans (11%) were registered on the condition that certain aspects of the plan text would be revised. The revisions were not made by the administrators and at the time of our review were still outstanding. Details are as follows:

- A pension plan had been issued a certificate of registration in September 2011 on the condition that issues with the plan text would be revised to bring it in accordance with legislation. These conditions were stipulated in a letter dated September 26, 2011. At the time of our review, the revisions had still not been fully made to the plan text. As a result, the plan was operating for a period of approximately 38 months while not in full compliance with legislation; and

- A pension plan had been issued a certificate of registration in April 2012 on the condition that issues with plan text would be revised to bring it in accordance with legislation. These conditions were stipulated in a letter dated April 4, 2012. The revisions were not made by the plan administrator and were not followed up by the Division until December 2014. At the time of our review, the revisions had still not been fully made to the plan text. As a result, the plan was operating for a period of approximately 33 months while not in compliance with legislation.

Finding

1. Two of the 19 pension plans registered during the period of our review were registered on the condition that the plan text would be amended. However, the required revisions were not made and as a result these pension plans have been operating for periods of approximately 38 and 33 months respectively, while not in full compliance with legislation.

Effective Dates

The effective date of a pension plan is the date on which the plan is considered active and in operation. It is the specific day, month, and year that benefits start to accrue to members and which contributions are required to be paid into the plan. The effective date of a plan is used to determine the date from which members are entitled to receive benefits from the plan.

Our review of the 19 pension plans, registered with the Division during the period April 1, 2011 to March 31, 2014, identified one plan with conflicting effective dates. The plan text had an effective date of April 1, 2010 while the registration form had an effective date of July 1, 2011. This discrepancy was not identified during the registration process and at the time of our review the issue had not been addressed by the Division.

Finding

2. The documentation used to support the registration of one of the 19 pension plans that had been registered during the period of our review had two different effective dates for the start of the plan. The effective date impacts when benefits start accruing to plan members.

Registration Process

The legislation has provisions related to the initial registration of pension plans. Once registrations are submitted they are reviewed by Division officials to ensure compliance with the legislation. If the plan is found to be in compliance, a certificate of registration is issued. The provisions of the legislation serve to protect the future pension entitlements of plan members and ensure they are treated equitably. As such, we would expect the registration process to be completed in a timely manner.

We examined all 19 pension plans that were registered with the Division during the period April 1, 2011 to March 31, 2014. From our review, we found that while all 19 pension plans had been issued a certificate of registration, this was not always done in a timely manner. Specifically, we found that the average length of time required to complete the registration process was 222 days, ranging from a high of 685 days to a low of 17 days.

Finding

3. The registration process for the 19 pension plans that had been registered during the period of our review was not always being completed in a timely manner. The average length of time required to complete the registration process was 222 days, ranging from a low of 17 days to a high of 685 days. As a result, instances of non-compliance may have gone undetected for extended periods of time reducing the opportunity for intervention and/or corrective action which may have put plan members at risk.

Pension Plan Amendments

Policy Directive No. 1 – Requirements for Registration, sets out the requirements for pension plan amendments. It states that, *"An application for registration of an amendment to a pension plan shall be made to the Superintendent within 60 days after the date on which the plan is amended and shall include*

a) a certified copy of the amending document; and

b) a review required under subsection 5(4) of the Regulations."

We selected a sample of 30 pension plans that had been amended during the period April 1, 2011 to March 31, 2014 and determined that a total of 36 amendments had been made over that time frame, however, only 34 were on file. At the time of our review, one pension plan had not filed the applicable documentation for two amendments that had occurred during their 2012 and 2013 fiscal years. As a result, this pension plan was not in compliance with legislation related to amendment filing requirements.

We found that for nine of the 34 amendments (26%) examined, the application for the registration of the amendment was not submitted within the required timeframe and there was no evidence that a written request for an extension to the 60 day deadline had been made. The average length of time the application for registration of the amendments was late was 185 days, ranging from a high of 487 days to a low of one day. Furthermore, there was no evidence that the non-compliance had been communicated to any of the plan administrators.

Once amendments to pension plans are submitted, they are reviewed by the staff of the Division and a notice of amendment is sent in response. Review of amendment documentation is required to ensure that the pension plan continues to be in compliance with legislation and thus continues to protect plan members. As such, we would expect the review of plan amendments to be completed in a timely manner.

We selected a sample of 30 pension plans which had amendments during the period April 1, 2011 to March 31, 2014 and reviewed the documentation related to the 34 amendments that had been submitted to the Division. From our examination, we found that the review of amendments was not always being completed by Division officials in a timely manner. Specifically we found:

- 27 of 34 amendment reviews (79%) sampled had been completed by Division officials. The average length of time required to complete a review was 296 days, ranging from a high of 1,029 days to a low of one day; and

- Seven of 34 amendment reviews (21%) sampled had not been completed by Division officials as of the time of our review. The average length of time the review of these amendments was outstanding was 522 days, ranging from a high of 1,380 days to a low of 265 days.

Findings

4. Required documentation for pension plan amendments was not always submitted to the Superintendent of Pensions. Documentation for two of the 36 plan amendments occurring during the period of our review had not been submitted.

5. Nine of the 34 amendments examined were not registered with the Department within 60 days of the amendment date as required. The average length of time the application for registration of the amendments was late was 185 days, ranging from a low of one day to a high of 487 days.

6. Based on our examination of 34 amendments which occurred during the period of our review, there was no evidence that the Department communicated with the pension plans who had not registered amendments within the required 60 days of the amendment date.

7. Pension plan amendments were not being reviewed by the Department in a timely manner. Of the 34 amendments examined we found that seven had not been reviewed by the Department. For the 27 amendment reviews completed by the Department, the average length of time required to complete a review was 296 days, ranging from a low of one day to a high of 1,029 days. As a result, instances of non-compliance may have gone undetected for extended periods of time reducing the opportunity for intervention and/or corrective action which may have put plan members at risk.

Reporting Requirements

Introduction

Once a pension plan has been registered with the Province, there are requirements that must be adhered to by the administrators of the plans to ensure continued compliance with legislation. Section 16 of the *Act* states that, *"An administrator of a pension plan shall file with the superintendent an information return for the plan in the form and containing the information required by the superintendent and as prescribed by the regulations."*

In addition, the *Regulations* state that pension plans that contain defined benefit provisions are required to have an actuarial valuation performed at various points in time over the life of the plan.

Our review of the reporting requirements pertaining to pension plans identified the following:

Annual Information Returns

The *Regulations* stipulate that the annual information return (AIR) is to be submitted within six months of the end of the fiscal year.

Information provided on the AIR includes, among other things:

- the name and address of the administrator;
- the end of plan year under review;
- plan amendments during the year;
- current service payments;
- special payments made during the year;
- various financial data applicable to the plan year;
- active membership; and
- plan membership.

The Division tracks AIR submission dates and information through a database. In advance of the AIR due dates, Division officials will make contact with pension plan administrators to remind them of the upcoming filing deadline.

We selected a sample of 35 pension plans for the period April 1, 2011 to March 31, 2014 and determined that 100 AIRs should have been submitted over that time frame, however, only 98 were on file. Details are as follows:

- One pension plan had not filed AIRs for their two most recent year ends, January 31, 2014 and January 31, 2013 until January 26, 2015. The Division charged and received late fees in both instances of non-compliance with AIR filing requirements.

In addition, we found that not all the AIRs were being submitted within six months of the end of the fiscal year as required by legislation. Specifically:

- 23 of the 35 plans (66%) sampled, or 36 of the 98 (37%) AIRs examined, were not submitted to the Division within the required timeframe and there was no evidence that plan administrators had made a written request for an extension to the six month deadline. The average length of time the AIRs were submitted late was 14 days, ranging from a high of 95 days to a low of one day.

- Of the 23 sampled pension plans that submitted their AIRs late, only two plans were charged a late fee.

- Although the Division communicated with the plan administrators who filed AIRs late, the communication of non-compliance was not consistently documented.

Once AIRs are submitted they are reviewed by the staff of the Division. Review of these returns is required to verify the information submitted is consistent with the information on file with the Division and to ensure that the pension plan is in compliance with legislation which serves to protect plan members. As such, we would expect these reviews to be completed in a timely manner.

We selected a sample of 35 pension plans for the period April 1, 2011 to March 31, 2014 and reviewed the 98 AIRs that had been filed over that timeframe. From our review, we found that the review of AIRs was not always being completed by Division officials in a timely manner. Specifically we found:

- 68 AIRs (69%) in our sample had been reviewed by Division officials. The average length of time required to complete a review was 163 days, ranging from a high of 510 days to a low of six days; and

- 30 AIRs (31%) in our sample were in the process of being reviewed by Division officials as of the time of our review. These 30 AIR reviews were at various stages of completion. The average length of time the review of these returns remained outstanding was 283 days, ranging from a high of 808 days to a low of 34 days.

Findings

8. Not all Annual Information Returns (AIRs) were being submitted to the Department within six months of the end of the fiscal year as required by legislation. During the period of our review, we examined a sample of 100 AIRs that were required to be filed. We found that:

    - One pension plan had not filed AIRs for the two most recent year-ends, January 31, 2014 and January 31, 2013 until January 26, 2015.

    - 36 of the remaining AIRs sampled were not in compliance with legislation as plan administrators had not filed the AIRs within six months of the end of the fiscal year as required. The average length of time the AIRs were submitted late was 14 days, ranging from a low of one day to a high of 95 days.

    - A late fee was imposed in only two instances.

    - Although the Division communicated with the plan administrators who filed AIRs late, the communication of non-compliance was not consistently documented.

9. AIRs were not always being reviewed by the Department in a timely manner. At the time of our review, we found that:

    - Of the 68 AIRs that had reviews completed, the average length of time taken to complete a review was 163 days, ranging from a low of six days to a high of 510 days. As a result, instances of non-compliance may have gone undetected for extended periods of time. In addition, the extended period of time required for review may limit the opportunity for intervention and/or corrective action which may have put plan members at risk.

    - 30 of the AIRs from our sample had not yet been fully reviewed. These 30 AIR reviews were at various stages of completion. The average length of time the review of these returns remained outstanding was 283 days ranging from a high of 808 days to a low of 34 days.

Actuarial Valuations

The *Regulations* require that DB plans have an actuarial valuation completed at least once every three years. When an actuarial valuation of the plan is performed, the actuary is required to provide opinions on the financial condition of the plan and on the contributions required to be made to the plan on the basis of two different scenarios:

1. Going Concern Valuation - assumes that the plan will be a going concern and will not terminate and that funds will be available when employees request their pension benefits; and

2. Solvency Valuation - assumes that the plan suddenly stops operating as of the valuation date. This is intended to test whether the plan has sufficient assets to provide an immediate payout of all benefits that have been earned to that date.

Actuarial valuations are required to be filed with the Superintendent no later than nine months after the review date.

We selected a sample of 35 pension plans for the period April 1, 2011 to March 31, 2014 and determined that 17 of them were defined benefit and, therefore, required an actuarial valuation to be submitted over the period of our review. Our review determined that three of the 17 DB plans (18%) had not submitted their actuarial valuations within nine months of the review date as required by legislation and there was no evidence that plan administrators had made a written request for an extension to the nine month deadline. The average length of time the actuarial valuations were submitted late was 146 days, ranging from a high of 387 days to a low of 23 days. Our review revealed that the Division informed plan administrators in all three instances of the late filing.

Actuarial valuations give insight into the financial health of DB pension plans. If the Division is aware of the information contained in these actuarial valuations and the financial circumstances surrounding DB pension plans it would better enable them to ensure pension plans are in compliance with legislation and that plan members are protected. As such, we would expect the Division to complete timely reviews of these documents.

From our review of the 17 actuarial valuations, we found that the review of actuarial valuations was not always being completed by Division officials in a timely manner. Specifically we found:

- 14 of the actuarial valuations (82%) in our sample had been reviewed by Division officials. The average length of time required to complete a review was 195 days, ranging from a high of 574 days to a low of one day; and

- Three of the actuarial valuations (18%) in our sample had not been reviewed by Division officials as at the time of our review. The average length of time the review of these actuarial valuations was outstanding was 409 days, ranging from a high of 1,000 days to a low of 113 days.

Findings

10. Actuarial valuations were not always filed with the Superintendent of Pensions within nine months of the review date, as required by legislation. Three of our sample of 17 defined benefit pension plans had not filed within nine months of the review date. The average length of time the actuarial valuations were submitted late was 146 days, ranging from a low of 23 days to a high of 387 days.

11. Based on our review of our sample of 17 defined benefit pension plans, for the three plans that were late in submitting the actuarial valuation, the Department communicated the non-compliance in all three instances.

12. Actuarial valuations were not always being reviewed by Division officials in a timely manner. For the 17 defined benefit pension plans we reviewed, we found that three actuarial valuation reviews had not yet been completed. The average length of time these reviews were outstanding was 409 days, ranging from a low of 113 days to a high of 1,000 days. As a result, instances of non-compliance may have gone undetected for extended periods of time. In addition, the extended period of time required for review may limit the opportunity for intervention and/or corrective action which may have put plan members at risk.

Surplus Payments and Transfers of Plan Assets

Introduction

If a pension plan does accumulate a surplus, a payment can be made to the employer. However, these payments are strictly guided by the *Act* and the *Regulations.* Division officials indicated that there were no surplus payments made by any pension plans during the period of our review.

Occasionally, plan assets are transferred between plans. The *Act* states that, *"A transfer of assets of a pension plan shall not be made from the pension fund of the plan to the pension fund of another pension plan unless*

a) *the contract or trust agreement of the receiving fund holder is filed with the superintendent and the receiving plan is registered under this Act*; *and*

b) *the superintendent has approved the transfer in writing"*.

Our review of pension plans that had transfers of plan assets identified the following:

Transfers of Plan Assets

We reviewed all three pension plans that had transfers of plan assets during the period of April 1, 2011 to March 31, 2014 and found that all three plan asset transfers were completed in accordance with legislation.

Finding

13. All three pension plans that had transfers of plan assets during the period of our review were completed in accordance with legislation.

Plan Terminations

Introduction

The employer and/or the Superintendent can elect to terminate a plan for any number of reasons. For instance:

- there is a suspension or cessation of employer contributions in respect of all or part of the plan membership;
- the employer has discontinued or is in the process of discontinuing all of its business operation or a part in which a substantial portion of its employees who are members of the plan are employed;
- the employer is bankrupt;
- there are no employees remaining in the pension plan;
- the superintendent is of the opinion that the plan has failed to meet the requirements prescribed by the regulations for solvency in respect of funding; or
- all or part of the business or assets of a predecessor employer's business are sold, assigned or otherwise disposed of and the successor employer who acquired the business or assets does not provide a pension plan for the members of the predecessor employer's plan who become employees of the successor employer.

Our review of terminated pension plans identified the following:

Plan Termination Requirements

The *Act* states that, *"An employer, or, in the case of a multi-employer pension plan, the administrator, who intends to terminate the whole or part of a pension plan shall notify in writing the superintendent and any other person or body who is affected of that intention at least 60 days before the date of the intended termination"*.

The Act also states that, *"On the termination of the whole or part of a pension plan, the administrator of the plan shall file with the superintendent*

a) a report required by the superintendent, within 6 months after the effective date of termination; and

b) all outstanding annual information returns up to the effective date of the termination, within 3 months after that date."

We reviewed all 14 pension plans that were terminated during the period of April 1, 2011 to March 31, 2014 and found that not all required termination documentation had been submitted within the required time frame. We found that two of the 14 pension plans (14%) sampled did not submit the required AIRs within three months of the effective date of termination as required by legislation.

Finding

14. Plan terminations were not always in compliance with legislation. We found that two of the 14 pension plans that were terminated during the period of our review had not submitted their annual information returns within three months of the effective date of termination as required.

Solvency Funding Relief

Introduction

Any deficiencies identified from a going concern valuation or a solvency valuation are required to be funded over a maximum period of 15 years and five years, respectively. The *Regulations* provide for some DB pension plans to be exempt from certain requirements, including making going concern and solvency deficiency payments.

Table 3 shows the pension plans which are excluded from each type of deficiency payment and for what period.

Table 3

Service NL
Pension Administration
Summary of Going Concern and Solvency Deficiency Exemptions

Pension Plan	Going Concern Deficiency Exemption	Period	Solvency Deficiency Exemption	Period
Public Service Pension Plans	Yes	Indefinite	Yes	Indefinite
Memorial University Pension Plan	No	N/A	Yes	January 1, 2011- December 31, 2015
Newfoundland and Labrador Municipal Employees Benefits Inc.	No	N/A	Yes	December 31, 2010 - December 31, 2015
Town of Happy Valley - Goose Bay	No	N/A	Yes	December 31, 2012 - December 31, 2015
City of St. John's	No	N/A	Yes	December 31, 2012 - December 31, 2015

Source: Service NL, Pension Benefit Standards Division

In June 2008, the Province amended the *Regulations* to provide for temporary solvency funding relief for defined benefit pension plans. There were separate funding relief options for regular DB pension plans and multi-employer defined benefit pension plans.

For regular DB pension plans there were three solvency funding relief options:

1. Part I - Consolidate previous solvency funding payment schedules and amortize the entire solvency deficiency over a single, new five year period;

2. Part II - Extend the funding period to ten years provided that no more than one-third of active plan members or non-active members and beneficiaries, including retirees, object to the extended payment period; and

3. Part III - Extend the solvency funding payment period to 10 years when the difference between the five year and 10 year level of payments is secured by a letter of credit.

In January 2012, the Province extended the temporary solvency relief for regular DB pension plans. The temporary relief was available for actuarial valuation reports with valuation dates between January 1, 2010 and January 1, 2013. The only difference between the three solvency relief options for regular DB pension plans was that Part I could only be used provided that consolidation under the option had not been previously applied during a prior solvency funding relief period.

Our review of pension plans that had availed of solvency funding relief identified the following:

Solvency Funding Relief Filing Requirements

The *Relief Regulations* outline specific requirements that are to be followed for plans availing of solvency relief. In addition, DB plans utilizing solvency funding relief are required to have a review of the plan completed in the form of an actuarial valuation. For pension plans availing of relief under Part I, the actuarial valuation is required to be completed at intervals not exceeding three fiscal years after the preceding review date. However, for plans availing of relief under Part II, the actuarial valuations are required to be completed at intervals not exceeding one fiscal year after the preceding review date. The actuarial valuations are required to be submitted within nine months of the plan year end.

We reviewed the four pension plans that had availed of solvency funding relief, two under Part I and two under Part II, during the period of April 1, 2011 to March 31, 2014 and found that not all of the actuarial valuations had been submitted within the required time frame. Details are as follows:

- One pension plan availing of Part II solvency relief did not file actuarial valuations due September 30, 2011 and September 30, 2012 until May 2014. In addition, the 2013 actuarial valuation which was due September 30, 2014 had not been submitted at the time of our review; and

- One pension plan availing of Part II solvency relief did not file an actuarial valuation due September 30, 2011 until May 2014. In addition, the 2013 actuarial valuation which was due September 30, 2014 had not been submitted at the time of our review.

Finding

15. Pension plans which availed of the Solvency Funding Relief provided by the Province were not always in compliance with legislation. Two of the four pension plans reviewed for compliance with solvency funding relief requirements had not submitted their actuarial valuations within nine months of the plan year end as required.

Inspections and Audits of Pension Plans

As previously stated, the Division is responsible for the administration and enforcement of the legislation that governs employer-sponsored pension plans established for Newfoundland and Labrador employees. The legislation contains many provisions that employers and administrators are expected to adhere to. For example, the *Act* requires administrators of pension plans, at least once every three years or at the request of a member or former member, to provide a written pension statement.

Inspections and audits are mechanisms that would enable the Division to uncover and correct instances of non-compliance with and misinterpretation of the legislation. Also, their existence would serve as a natural deterrent to non-compliance. Although, the *Act* gives the Superintendent the power to conduct inspections and/or audits of pension plans registered with the Province, Division officials indicated that they do not occur.

Finding

16. Although the *Pension Benefits Act* gives the Superintendent of Pensions the authority to conduct inspections and audits of pension plans registered with the Province, none have been completed.

Recommendations

1. The Department should communicate instances of non-compliance to pension plan administrators on a timely basis.

2. The Department should consider implementing a policy for imposing penalties in instances of non-compliance.

3. The Department should implement processes that would enable them to complete reviews of registrations, amendments, annual information returns and actuarial valuations, in a timely manner.

4. The Department should investigate the development of a policy for identifying and performing external inspections/audits of pension plans registered with the Province.

Service NL Response

1. ***The Department should communicate instances of non-compliance to pension plan administrators on a timely basis.***

   Department's response:

   In most cases, pension plan documentation is filed within the legislated timeframes. When documentation is filed late, instances of non-compliance are generally communicated to pension plan administrators but this communication has not consistently been documented by the Division.

   The Department will implement a process whereby communication of non-compliance (for late filing of AIRs, amendments, or actuarial reports) is documented and followed-up on in a timely manner.

2. ***The Department should consider implementing a policy for imposing penalties in instances of non-compliance.***

   Department's response:

   In accordance with a directive under the Act, late filing fees for AIRs can be imposed by the Division and the Division has imposed these penalties where appropriate (including examples of penalties imposed during the period of the review). However, rather than have a strict policy that must be adhered to, the Division's experience is that compliance is more often achieved (or the period of non-compliance is minimized) by working with the plan administrators and third-party professionals and using discretion when imposing penalties.

   The Department does not have an overall concern with late filings and does not see the need to impose additional late filing penalties at this time.

3. ***The Department should implement processes that would enable them to complete reviews of registrations, amendments, annual information returns and actuarial valuations, in a timely manner.***

   Department's response:

   In the majority of cases, there is a timely review of documentation filed with the Division and the current process, of a preliminary review upon receipt, allows the Division to prioritize and first address any higher risk issues. This practice significantly reduces this risk of a pension plan not being in compliance with the legislation.

   The Department will work to improve the average time required to complete reviews of new plan registrations, amendments, AIRs, and actuarial valuations, recognizing the potential complexity with certain documentation.

4. The Department should investigate the development of a policy for identifying and performing external inspections/audits of pension plans registered with the Province.

Department's response:

The practice of the Division has been to rely on the reporting requirements and the Division's review of these filings for identification of non-compliance. Given the involvement of third party professionals with the pension plans, the risk of systematic issues are limited. However, if an issue is identified or brought to the Division's attention for a particular pension plan, an audit would be performed where deemed necessary.

While the Department does have the authority to perform inspections, as required, it does not believe regular onsite audits would be an efficient use of departmental resources at this time.

PART 3.10

DEPARTMENT OF TRANSPORTATION AND WORKS

USE OF EXTERNAL CONSULTANTS

Summary

Introduction

The Department of Transportation and Works (the Department) is responsible for the administration, supervision, control, regulation, management and direction of all matters relating to transportation and public works. The Department has responsibility for the management of approximately 640,000 square meters of floor space, in 872 buildings, on 366 sites across the Province; and the construction of new buildings and the management of other capital projects for Provincial Government departments and Provincial Government-funded entities.

The various headquarters and regional divisions of the Works Branch (the Branch) are responsible for the provision of building design and construction management services throughout the Province and to Government client departments. In addition, the Building Design and Construction Division provides advisory services to the regional offices and client departments. The mandate of the Branch is to construct, acquire and/or manage building infrastructure, leased space and related services for Provincial Government and related agencies. To fulfill this mandate, the Department uses the professional services of external consultants, specifically engineering, design and architectural consultants.

The Construction of Roads and Buildings Program had the largest expenditure for professional services, totaling $28.9 million, over the period April 1, 2011 to March 31, 2014.

Objectives

The objectives of our review were to assess whether the Department hires external consultants in accordance with the *Guidelines Covering the Hiring of External Consultants* (Consultants Guidelines) and sound public sector practices. Our review assessed whether:

1. External consultants were acquired competitively through an open, fair and transparent procurement process;

2. Systems and procedures were in place to ensure that consulting services were managed and monitored to ensure satisfactory completion of assignments; and

3. An evaluation of the consultant's performance was completed to assess the quality of the results.

Scope

Our review covered the period April 1, 2011 to December 31, 2014. We reviewed consultants engaged on new construction and major renovation projects completed during that period by the Department (including projects sponsored by other departments). For the purposes of this review we examined all consultant contracts with an original contract value in excess of $100,000.

Sixteen new construction and major renovation projects were completed during the period of our review. We reviewed all 16 of these projects.

In addition, we obtained information on 71 consultant contracts for other services such as assessment of building condition and environmental assessments to determine if monies spent on these contracts were in accordance with the *Guidelines Covering the Hiring of External Consultants*.

We did not review and comment on the quality of the detailed engineer/technical reviews completed by Department officials, nor did we review the quality of the work of the external consultants.

We completed our review in April 2015.

Conclusions

Objective 1

External consultants were not acquired in accordance with the *Guidelines Covering the Hiring of External Consultants* and as a result, they were not hired competitively through an open, fair, and transparent procurement process.

Objective 2

The Department had systems and procedures in place to manage and monitor consultants. However, the procedures did not include obtaining Treasury Board approval for payments that were in excess of 110% in the aggregate of the approved original contract amount as required under the *Guidelines Covering the Hiring of External Consultants*.

Objective 3

The Department implemented a performance evaluation system for consultants in 2012. For the 16 major engineering, design and architectural projects we reviewed, the performance evaluation system was not yet in effect and consequently the Department did not complete performance evaluations for the consultants assigned to these projects. The results from evaluations are not used to assess the suitability of a consultant for future projects.

Findings

Hiring of External Consultants

1. The Department is not engaging consultants in accordance with the Consultants Guidelines. For the 16 major engineering, design and architectural projects reviewed, we did not identify any instances where a ministerial committee, as required in Section 4.2, was used to appoint these consultants.

2. The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the appointment process.

3. The Request for Expressions of Interest and Direct Appointment Processes used by the Branch does not provide a competitive, open, fair, and transparent procurement process.

4. There is insufficient documentation to support the rationale for the selection of a consultant for capital projects using the Direct Appointment and Request for Expressions of Interest methods.

5. The Department maintains a Registry of Consultants that can be consulted when selecting consultants for future projects.

Monitoring and Management of External Consultants

6. We found that monitoring was completed in 11 of the 16 major engineering, design and architectural projects reviewed. In three of the five remaining projects, the Branch indicated that monitoring was completed but could not provide formal documentation to verify that monitoring was completed. In two of the five projects, the projects were completed prior to the implementation of a formal monitoring policy by the Department.

7. For the 16 major engineering, design and architectural projects reviewed, we did not identify any instances where the scope of the project exceeded the initial planned project scope.

8. In 9 of the 16 major engineering, design and architectural projects we reviewed, the Department failed to obtain Treasury Board approval for 10 contracts where payments were in excess of 110%, in the aggregate of the approved original contract amount, as required.

9. The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the requirement to obtain Treasury Board approval for payments that were in excess of 110%.

10. In 50 of 71 consultant contracts for other services, the Department failed to obtain Treasury Board approval for payments that were in excess of 110%, in the aggregate of the approved original contract amount, as required. The total value of the payments that exceed 110% of the original contract value totaled $3.2 million.

Performance Evaluation of External Consultants

11. Department implemented a performance evaluation system for consultants in January 2012. For the 16 major engineering, design and architectural projects we reviewed, the performance evaluation was not yet in effect and consequently the Department did not complete performance evaluations for the consultants assigned to these projects.

12. The Department does not use performance evaluations that have been conducted to assess the suitability of a consultant for a future project.

Recommendations

1. The Department should comply with the *Guidelines Covering the Hiring of External Consultants:*

    - for engaging consultants on capital projects, and

    - obtain Treasury Board approval to authorize payments to consultants that are in excess of 110%, in the aggregate, of the approved original contract amount.

2. The Department should continue to complete performance evaluations and use the results of those evaluations to assist with the selection of consultants for future projects.

Objectives and Scope

Objectives

The objectives of our review were to assess whether the Department of Transportation and Works (the Department) hires external consultants in accordance with the *Guidelines Covering the Hiring of External Consultants* and sound public sector practices. Our review assessed whether:

1. External consultants were acquired competitively through an open, fair and transparent procurement process;

2. Systems and procedures were in place to ensure that consulting services were managed and monitored to ensure satisfactory completion of assignments; and

3. An evaluation of the consultant's performance was completed to assess the quality of the results.

Scope

Our review covered the period April 1, 2011 to December 31, 2014. We reviewed consultants engaged on new construction and major renovation projects, involving engineering, design and architectural services, that were completed during this period by the Department (including projects sponsored by other departments). For the purposes of this review we examined all consultant contracts with an original contract value in excess of $100,000.

Sixteen new construction and major renovation projects were completed during the period of our review. We reviewed all 16 of these projects.

In addition, we obtained information on 71 consultant contracts for other services such as assessment of building condition and environmental assessments to determine if monies spent on these contracts were in accordance with the *Guidelines Covering the Hiring of External Consultants*.

We did not review and comment on the quality of the detailed engineer/technical reviews completed by Department officials, nor did we review the quality of the work of the external consultants.

We completed our review in April 2015.

Background

The Department of Transportation and Works (the Works) is responsible for the administration, supervision, control, regulation, management and direction of all matters relating to transportation and public works. The Department manages approximately 640,000 square meters of floor space, in 872 buildings, on 366 sites across the Province, the construction of new buildings and the management of other capital projects for Provincial Government departments and Provincial Government-funded entities.

The various headquarters and regional divisions of the Works Branch (the Branch) are responsible for the provision of building design and construction management services throughout the Province and to Government client departments. In addition, the Building Design and Construction Division provides advisory services to the regional offices and client departments. The mandate of the Branch is to construct, acquire and/or manage building infrastructure, leased space and related services for Provincial Government and related agencies. To fulfill this mandate, the Department uses the professional services of external consultants, specifically engineering, design and architectural consultants.

Table 1 summarizes the professional services expenditures by program for the years ended March 31, 2012 to 2014. The Construction of Roads and Buildings Program had the largest expenditure for professional services, totaling $28.9 million, during this period.

Table 1

Department of Transportation and Works
Summary of Capital Professional Service Expenditures by Program
For the Fiscal Years Ended March 31
(000's)

Program	2012	2013	2014	Total per Program
Maintenance of Roads and Buildings	$ 129	$ 31	$ 38	$ 198
Construction of Roads and Buildings	10,574	10,090	8,202	28,866
Transportation Services	2,926	772	743	4,441
Total	**$ 13,629**	**$ 10,893**	**$ 8,983**	**$ 33,505**

Source: Department of Finance, Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

Table 2 shows the expenditures for professional services on capital projects by type of construction within the Program for the years ended March 31, 2012 to 2014.

Table 2

Department of Transportation and Works
Professional Service Expenditures - Construction of Roads and Buildings
For the Fiscal Years Ended March 31
(000's)

Type - Construction of Roads and Buildings	2012	2013	2014
Road Construction	$ 8,147	$ 7,150	$ 5,985
Building Construction	2,427	2,940	2,217
Total	**$ 10,574**	**$ 10,090**	**$ 8,202**

Source: Department of Finance, Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

In addition to the professional services for external consultants that is directly charged to the Department, additional expenditures for external consultants for construction and building design are charged to other sponsoring departments. The Branch normally engages consultants, and directly oversees the work of the consultant, for capital projects sponsored and paid for by these other departments.

Table 3 shows the expenditures for professional services on capital projects sponsored by the three other departments with the most significant use of external consultants for the fiscal years ended March 31, 2012 to 2014.

Table 3

Department of Transportation and Works
Professional Services Expenditures – Other Departments
For the Fiscal Years Ended March 31
(000's)

Department	2012	2013	2014
Health and Community Services	$ 16,622	$ 9,195	$ 6,628
Education and Early Childhood Development	5,408	4,559	6,006
Justice and Public Safety	331	146	237
Total	**$ 22,361**	**$ 13,900**	**$ 12,871**

Source: Department of Finance, Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

Consultants Guidelines

The *Guidelines Covering the Hiring of External Consultants* (Consultants Guidelines) issued by the Treasury Board in December 1992 (updated in August 1993) are the primary authority governing the process to be followed for the selection of external consultants.

The Consultants Guidelines define an external consultant as "*a private individual, group of individuals, company or institution with a high level of attainment in a professional, scientific, technical or managerial field which is engaged directly by a government department to perform specific work of an advisory nature not covered under the* Public Tender Act*.*"

Section 3.1 of the Consultants Guidelines establishes the overall policy to be followed in utilizing the Consultants Guidelines and states:

> "*It is the intention of Government to employ, to the extent feasible, the practice of requesting multiple proposals when engaging the services of external consultants. Government favours a public request for proposals and encourages departments to use this method whenever it is feasible to do so.*
>
> *Government appreciates that there may exist circumstances which mitigate against the public calling of proposals, and, consequently, permits departments to deviate from this preferred method. In such cases, departments are to invite proposals from any competent consultants as known to the departments; three proposals being considered as a minimum number.*
>
> *Furthermore, even though these Guidelines identify practical exceptions and exemptions, departments are cautioned to suspend the public calling of proposals only after serious consideration.*"

Section 3.4(b) of the Consultants Guidelines provides direction as to the process to be utilized when engaging consultants for the express purpose of design or project management of the construction or major renovation of a Government facility, water and sewer project, or public road at different expenditure thresholds. Section 4.2 of the Consultants Guidelines more specifically addresses the selection process to be used for engineering, design and architectural consultants.

Section 2.4 of the Consultants Guidelines outlines the approval process required when costs exceed 110% of the original contract amount.

Project Management and Design Administration Manual

The Project Management and Design Administration (PMDA) Manual was developed and maintained by the Branch. The purpose of the PMDA is to provide standards, guidelines and instructions for the delivery of projects. Included within the scope of the PMDA are more detailed policies and procedures related to engaging, monitoring, and evaluating the work of consultants.

Four Stage Approval Process for Capital Projects

Government currently has a four stage approval process for capital projects. Cabinet or Treasury Board approval is required to move to each successive stage of a proposed project. The Consultants Guidelines provide that the same consultant can be retained where there are multiple phases to a project. When Cabinet or Treasury Board does not approve moving to the next stage, the project ceases. The four stages of the approval process are as follows:

- Stage one - Approval in Principal. At this stage Cabinet provides approval for the sponsoring department to more thoroughly define the scope of a proposed capital project. The sponsoring department would prepare and submit a high level overview of the proposed project for Cabinet approval.

- Stage two - Approval to Design. In this stage Cabinet provides approval for the design to begin on a capital project. It is at the design stage where a consultant would be engaged to undertake the design work.

- Stage three - Approval to Tender. In this stage Treasury Board would provide approval to issue a tender in accordance with the *Public Tender Act*. The tender would be based on the design work completed by the consultant and approved by the sponsoring department.

- Stage Four - Approval to Award. In this stage authority to award a contract to the preferred bidder that was determined through the public tender process is at the Deputy Minister level if the project is within 10% of the pre-tender estimate and the project is within budget. If not, the Department will report to Treasury Board.

Detailed Observations

1. Hiring of External Consultants

Objective

To assess whether external consultants were acquired in accordance with the Consultants Guidelines competitively through an open, fair, and transparent procurement process.

Conclusion

External consultants were not acquired in accordance with the *Guidelines Covering the Hiring of External Consultants* and as a result, they were not hired competitively through an open, fair, and transparent procurement process.

Introduction

A competitive, open, fair and transparent process for engaging consultants can contribute greatly to the success of a project. Consultants are engaged to assist the Branch on projects that can routinely exceed $10 million, and in some instances $100 million, in construction related costs, as well as smaller projects. A selection process designed to obtain the best consultant for a project provides greater assurance that the project will be completed in accordance with established standards; will be the most appropriate design for the intended use; will minimize design errors and omissions; and will be completed in the most cost effective manner possible.

Consultants are also involved, to varying degrees, with the construction process. A consultant with appropriate expertise and experience can aid the Branch in ensuring a smooth construction process and assist in mitigating or addressing any conflicts or issues that may arise during the construction process.

Terms of Reference

Prior to engaging a consultant, the Branch prepares documentation that outlines the scope of the intended project. Depending on the nature of a project, the level of detail in the initial project documentation can vary. In some cases, there may be less initial information as greater reliance will be placed on the specialized expertise of the consultant to assist the Branch in refining the scope and requirements of a project. Consultants are generally presented with a “Project Brief” that details the scope and details of a project. The Project Brief would not include cost information as this is considered to be internal information at this point of the project and is subject to further refinement.

Selection of Consultants

Section 3.4(b) of the Consultants Guidelines requires that, *"When engaging consultants for the express purpose of design or project management of the construction or major renovation of a Government facility, water and sewer project, or public road that:*

- *Departments may use their discretion and not request limited or public proposals when fees and expenses are not estimated to exceed $100,000.*

- *Departments may suspend the requirement to request public proposals but must request limited proposals when total consultant fees and expenses are estimated to be in range of $100,000 - $150,000.*

- *Departments must prepare and advertise a public "Request for Proposals" when total consulting fees and expenses are estimated to exceed $150,000.*

- *If a department deems it impractical to request either type of request for proposal for those projects in excess of $100,000, it must receive specific Treasury Board approval to suspend the request for proposals.*

Furthermore Section 4.2 of the Consultants Guidelines specifically addresses the selection of engineering, design and architectural consultants and provides that *"appointments of engineering, design and architectural consultants, which would otherwise have been decided by cabinet, shall be decided by a Committee consisting of the Minister of Works, Services and Transportation as Chairperson, and the Ministers of Industry, Trade and Technology, and Justice, with the Committee to choose from a list of consultants prepared by officials in the Department calling proposals. The list is to include as supporting information, the number and value of recent contracts awarded all of the proponents for the specific project.*

For the 16 major engineering, design and architectural projects that we reviewed all 17 consultant contracts associated with these projects were over $150,000 and thus according to the Consultants Guidelines would require a Request for Proposal (RFP).

The Minister of Transportation and Works (the Minister), who is responsible for the appointment of consultants, prescribes the specific process to be used to engage consultants. Consultants are engaged in one of three ways:

- RFP is a public request for consultants to submit formal proposals. Evaluations of received proposals are based on established criteria that rank the proposals on experience, technical and financial details. The criteria on which proposals are evaluated include relevant experience and competencies, project methodology, references, results of interviews, overall quality of proposal, and cost. After the proposals are ranked, a formal recommendation is made to the Minister as to the preferred consultant.

- Request for Expression of Interest (EOI) is a public request for consultants or a request to a limited number of consultants to gauge their interest, availability, planned organizational set-up, and their proposed costs for a project.

- Direct Appointment process involves a number of steps including:
    - The Consultant Selection Advisory Committee comprised of senior officials from the Works Branch selects qualified consultants from the Departmental Consultant Registry based on the scope of the work required.
    - The Minister selects a consultant from the listing of qualified consultants provided by the Committee.
    - Once the Minister selects a consultant then the consultant is invited to submit a proposal to the Department for evaluation.
    - If the proposal is deemed to be acceptable, a contract is entered into for the work.

The Department indicated that RFPs have only been used in very rare occasions and for projects that require more highly specialized expertise. The majority of consultants are appointed either by the Minister through an EOI or by Direct Appointment. The Department also indicated that the use of EOIs to appoint consultants versus direct appoints has increased in recent years.

For the 16 projects reviewed, in six projects consultants were hired through an EOI and in ten projects consultants were hired through Direct Appointments. We did not identify any instances where a ministerial committee as outlined in Section 4.2 was used to appoint consultants as required by the Consultants Guidelines.

The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the appointment process for consultants and to do so without the use of ministerial committee.

Findings

1. The Department is not engaging consultants in accordance with the Consultants Guidelines. For the 16 major engineering, design and architectural consultant projects reviewed, we did not identify any instances where a ministerial committee, as required in Section 4.2, was used to appoint these consultants.

2. The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the appointment process.

3. The Request for Expressions of Interest and Direct Appointment Processes used by the Branch does not provide a competitive, open, fair, and transparent procurement process.

Documentation of Consultant Selection

The Direct Appointment and EOI methods of appointment did not result in sufficient documentation to support the rationale for the selection of a particular consultant for a capital project. The only documentation available to support a Direct Appointment might be a listing from the Consultant Registry and the resulting proposal that is submitted. The EOI process requires that consultants pre-selected by the Minister submit proposals to the Department. However, there is no formal documented analysis of the proposals received in response to the EOI to ensure that the best suited consultant (weighing technical, financial, and past performance considerations) is appointed.

The RFP does have a formal evaluation process, however RFPs are rarely used in the appointment process.

Finding

4. There is insufficient documentation to support the rationale for the selection of a consultant for capital projects using the Direct Appointment and Request for Expressions of Interest methods.

Consultant Registry

Section 3.2 of the Consultant Guidelines states that, "*Departments are encouraged to prepare and maintain an up-to-date list(s) of appropriate consultants who have expressed an interest in submitting proposals for government work. The consultant list(s) shall be an item of public knowledge and an updating process be such as to provide opportunities to newer entrants*."

The Department does maintain a Registry of Consultants (the Registry) for consultants that wish to provide services to the Department. Formal applications are to be completed by consultants that wish to be included in the Registry. The applications are available on the Departmental web site and it is the responsibility of the consultants to register with the Department and update their information. The application process allows consultants to be included in the Registry under a specific discipline, for which they have relevant work experience and qualifications (e.g. architectural, mechanical, electrical, and structural).

Applications are to be completed in a timely manner any time there is a change in the structure (including team members), ownership, name, address or other pertinent information of a consulting firm. These submissions are reviewed by Senior Officials in the Works Branch to ensure that the consultant meets the professional requirements for their discipline and, subsequently their information is added to or updated in the Consultant Registry Database on a regular basis. Candidates are selected from the current version of the database.

Finding

5. The Department maintains a Registry of Consultants that can be consulted when selecting consultants for future projects.

2. Monitoring and Management of External Consultants

Objective

To assess whether systems and procedures were in place to ensure that consulting services were managed and monitored to ensure satisfactory completion of assignments.

Conclusion

The Department had systems and procedures in place to manage and monitor consultants. However, the procedures did not include obtaining Treasury Board approval for payments that were in excess of 110% in the aggregate of the approved original contract amount as required under the *Guidelines Covering the Hiring of External Consultants*.

Overview

Systems, policies, and procedures to manage and monitor services provided by a consultant can assist in ensuring that a consultant has accurately understood the dimensions of a project and their particular role. A monitoring process would include regular meetings, formal checkpoints, and status updates. An effective monitoring program can identify potential issues and provide the opportunity to mitigate or address these issues with minimal impact on the project.

Policy and Procedures

The PMDA is the primary source of the policies and procedures that are to be utilized by the Branch to manage and monitor consultants.

Monitoring of Timelines

Article VI of the standard contract provides details of the mutually agreed upon start and completion dates. Schedule IV of the standard contract provides further details of the agreed upon schedule of key services to be provided or key milestones to be met and the agreed upon due date.

For the 16 project files reviewed, we did not identify any instances where the project timelines exceeded the agreed upon completion dates as a result of the work of the consultant.

Monitoring of Design Work

Section 5.4.1 of the PMDA manual states, "*Submissions of working drawings and specifications shall be made at 33%, 66% and 99% (Pre-Tender) stages of detailed design development. Various levels of review will be performed by TW at each stage. Comments will be returned to the Consultant for incorporation into the design.*"

The reviews conducted by the Branch at each of these stages were the primary means by which the Branch monitors the design work of the consultants. The Branch receives detailed technical drawings from consultants and reviews these documents to provide feedback on matters that the consultant must address. Branch staff regularly meets with the consultant to provide this feedback. Agreed upon changes are reflected in the next draft of project documents.

For the 16 projects reviewed, we found that monitoring was completed in 11 instances. For three of the remaining five projects, the Branch was not able to provide formal documentation to verify monitoring was completed. The Branch indicated that reviews were completed, however, they were unable to locate the related documentation. The Branch did provide other documentation (eg. Design Development Reports - documentation prepared by the consultants) where there was evidence of a review by Branch officials through notations and comments on the documentation. In two of these five projects, the Department indicated that the project was completed prior to the establishment of a formal written feedback report and that feedback would have been provided informally through emails, discussions, and meetings.

Finding

6. We found that monitoring was completed in 11 of the 16 major engineering, design and architectural projects reviewed. In three of the five remaining projects, the Branch indicated that monitoring was completed but could not provide formal documentation to verify that monitoring was completed. In two of the five projects, the projects were completed prior to the implementation of a formal monitoring policy by the Department.

Monitoring Scope of Projects

The Consultants Guidelines states that "*in situations of multi-phased projects where it is in Government's best interest, a department has discretionary authority to retain the same consultant on all phases without a need to invite proposals for each phase*". A consultant's design would generally encompass all phases of a project. Therefore, it is accepted that a consultant continue to work on all phases of a project.

Government uses a multi-stage approval process for capital projects. Once selected, a consultant would normally be retained for all stages of the approval process. Once Cabinet approves proceeding to the next stage of a project, a Change Order may be required to authorize the consultant to continue and be paid for their work. If a project is cancelled, then the consultant is not required to be paid for the work that was not completed.

For the 16 major engineering, design and architectural projects reviewed, we did not identify any instances where the scope of the project exceeded the initial planned scope.

Finding

7. For the 16 major engineering, design and architectural projects reviewed, we did not identify any instances where the scope of the project exceeded the initial planned project scope.

Approval of Contract Cost Increases

Section 2.4 of the Consultants Guidelines requires that "*In cases of contracts awarded at set amounts, departments must receive Treasury Board approval to authorize payments which are in excess of 110 percent, in the aggregate, of approved contractual amounts.*"

Schedule II of the standard contract provides details of the initially agreed upon services and costs. This Schedule also provides for other reimbursable allowances and costs, such as testing of materials that can be included within the overall scope of the project, and therefore included in the total due to a consultant.

We reviewed 16 major engineering, design and architectural projects and found ten (62.5%) contracts where the total cost of consultant services provided had exceeded 110% of the initial contracted amount. In none of these instances was the Treasury Board asked to approve the payments in excess of 110% of the approved contract amount. The overages ranged from 114.4% to 233.1%. Of the 10 contracts over 110% of the initial contracted amount we found:

- A parking garage project with an original contract for $486,675 had change orders totaling $542,753 resulting in total payments to the consultant of $1,029,428 (211.52% of original contract).

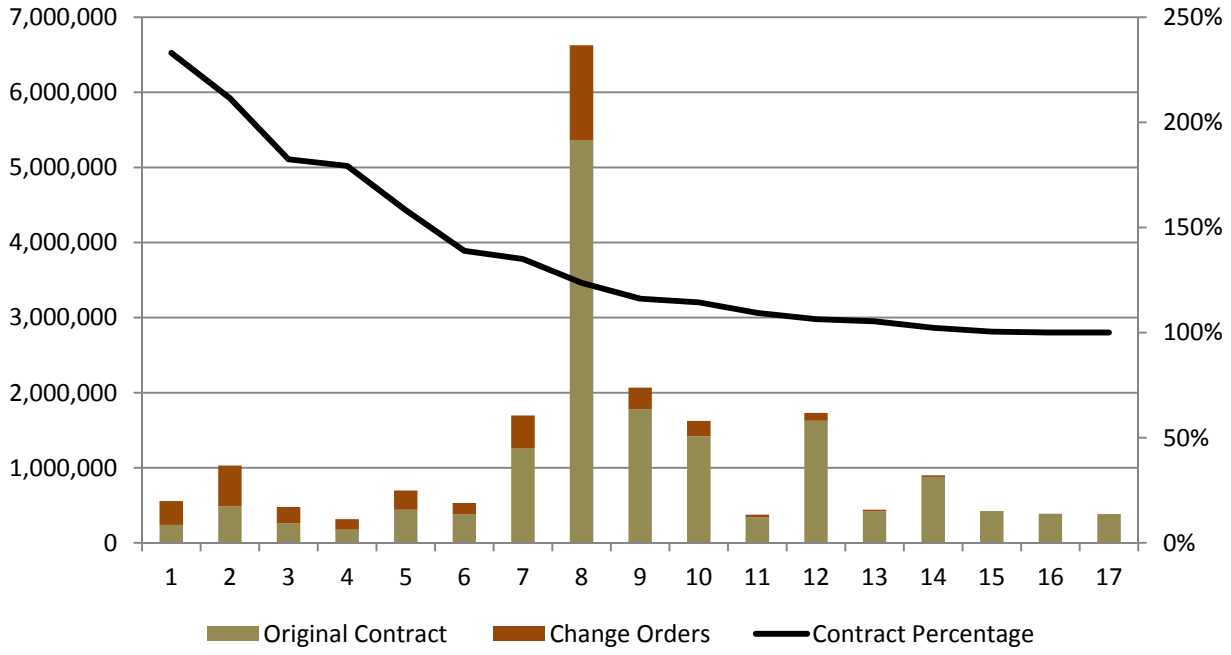
- One phase of an Aquaculture Centre project with an original contract for $239,000 had change orders totalling $318,038 resulting in total payments to the consultant of $557,038 (233.1% of the original contract).

The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the requirement to obtain Treasury Board approval for payments that were in excess of 110%.

Chart 1 provides details on the 17 major engineering, design and architectural consultant contracts reviewed and the original and final contract costs.

Chart 1

Department of Transportation and Works
Original Contract Amount and Change Orders
April 1, 2011 to December 31, 2014



Note: Contract 1 and 4 relate to two phases of a project that utilized the same consultant under 2 different consulting contracts.

One of the most common reasons for cost increases requiring change orders is additional work related to the LEED Program. Our review of the 16 projects selected, found there were significant change orders issued to address the costs of obtaining LEED certification.

Department officials indicated that LEED certification was a requirement of the Build Better Buildings (BBB) policy released by the Province in September 2010. The BBB policy required that, *"Projects that have received or have been approved for provincial funding prior to the release of this policy are expected to adhere to BBB to the greatest extent practical."* As a result, change orders were issued to include LEED requirements for projects already in progress.

Finding

8. In 9 of the 16 major engineering, design and architectural projects we reviewed, the Department failed to obtain Treasury Board approval for 10 contracts where payments were in excess of 110%, in the aggregate of the approved original contract amount, as required.

9. The Department was not able to provide documentation to support an exemption from the Consultants Guidelines to deviate from the requirement to obtain Treasury Board approval for payments that were in excess of 110%.

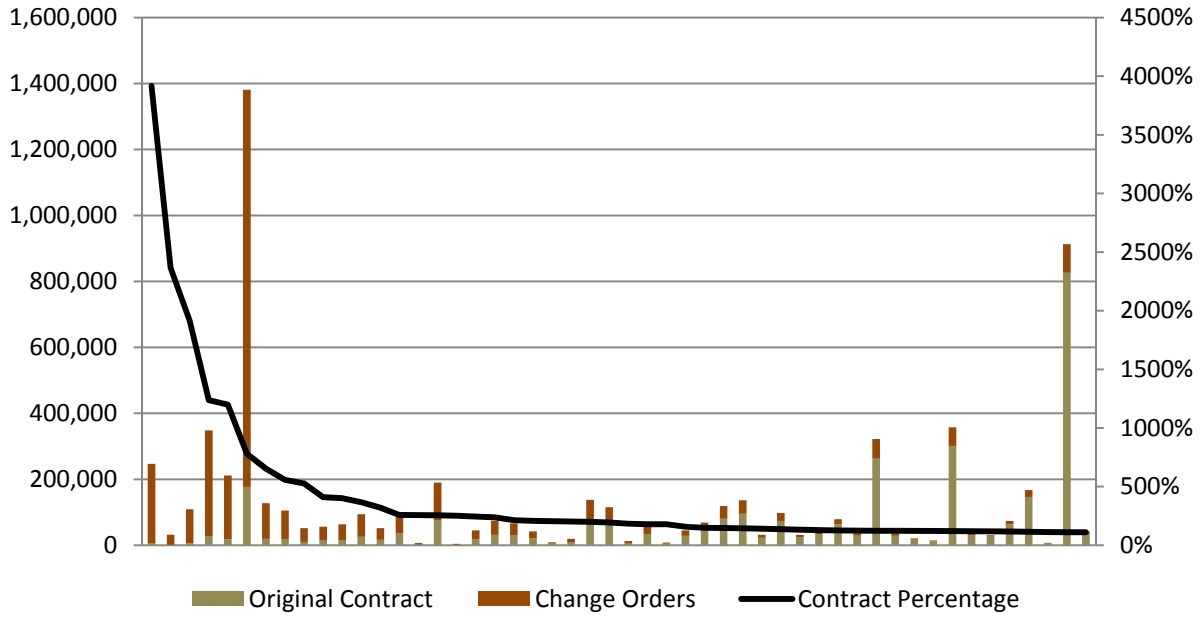
Approval of Contract Cost Increases – Other Consultants Contracts

As a result of determining the Department was not obtaining Treasury Board approval for payments that were in excess of 110%, in the aggregate of the approved original contract amount, we inquired as to other projects on which consultants were engaged by the Department during the timeframe of our review. These contracts would be for numerous other services such as the assessment of the condition of a building (or a component of a building such as a roof), environmental assessments (and potentially any required remediation), planning and other services.

The Department responded with a list of 71 consultant contracts with a total original contract value of $4.6 million. We found that 50 contracts had change orders issued that increased the value of the contract by over 110% in the aggregate of the approved original contract amount. None of these contracts received Treasury Board approval for the payments that were in excess of 110% of the original contract amount. Chart 2 provides details on the 50 consultant contracts that had change orders issued that increased the value of the contract by over 110%, in the aggregate of the approved original contract amount.

Chart 2

Department of Transportation and Works
Other Consultant Contracts with Change Orders over 110% of Original Contract Value
April 1, 2011 to December 31, 2014



Source: Department of Transportation and Works

Table 4 shows the amount of the original contracts and the revised amount of these 50 contracts where there were payments over 110%, in the aggregate of the original contract amounts.

Table 4

Department of Transportation and Works
Other Consultant Contracts with Payments in Excess of 110% of Original Contact Value
For the period April 1, 2011 to December 31, 2014

Details	Amount
Revised contract value	$ 6,466,210
Original contract value	3,009,126
Increase in contract value	3,457,084
Maximum increase before Treasury Board approval required	300,913
Payments without Treasury Board approval	**$ 3,156,171**

Source: Department of Transportation and Works

For these 50 contracts we found:

- A contract for an environmental site assessment with an original value of $6,300 had change orders totaling $240,515, an increase of 3,918% over the original contract.

- A contract for a due diligence review for a health care facility with an original value of $177,000 had change orders totaling $1,204,000, an increase of 780% over the original contract.

- The average amount paid that exceeds the threshold for Treasury Board approval was $63,124.

Finding

10. In 50 of 71 consultant contracts for other services, the Department failed to obtain Treasury Board approval for payments that were in excess of 110%, in the aggregate of the approved original contract amount, as required. The total value of the payments that exceed 110% of the original contract value totaled $3.2 million.

3. Performance Evaluation of External Consultants

Objective

To assess whether an evaluation of the consultant's performance was completed to assess the quality of the results.

Conclusion

The Department implemented a performance evaluation system for consultants in 2012. For the 16 major engineering, design and architectural projects we reviewed, the performance evaluation system was not yet in effect and consequently the Department did not complete performance evaluations for the consultants assigned to these projects. The results from evaluations are not used to assess the suitability of a consultant for future projects.

Overview

A post project evaluation system can assist both the Branch and consultants in improving on existing processes. An objective evaluation provides the Branch with a means for identifying consultants who perform quality work, provides data that can be used in future selection processes and provides consultants with an opportunity to improve performance by identifying strengths and weaknesses.

PMDA - Monitoring and Evaluation of Consultants

Section 3.3.3.7 of the PMDA contains policies and procedures that address monitoring and the evaluation of consultants. The current evaluation process was introduced in January 2012. Monitoring and evaluation is required to be completed for all design contracts with consultants.

The evaluation process begins after the award of the construction contract, with the initial assessment completed by the Design Manager. The evaluation is then completed by the Construction Manager once construction is completed. Consultant performance is evaluated on a point based system and the overall score is weighted using the following categories:

- **Design phase - 75%**
  This category would consider the consultants knowledge of the client's needs, quality of documents, whether building code requirements are met and documented, budget management, and meeting deliverable deadlines.

- **Contract administration - 20%**
  This category would consider whether review of shop drawings was thorough and timely, change orders were issued with appropriate documentation, job meetings were regularly attended, requests for information were timely, and solutions provided on matters were appropriate, creative and cost effective during conflict resolution.

- **Contract close-out - 5%**
  This category would consider if the consultant monitored construction progress and the status of defective work, and provided all required documentation.

The evaluation process currently in use by the Branch was not in place for the 16 projects we reviewed and no performance evaluations were completed for these projects.

The Branch has completed consultant evaluations for smaller projects that have commenced and been completed since 2012. As previously noted, large capital projects are often multi-year and the current evaluation process is still in progress for the larger projects.

Finding

11. The Department implemented a performance evaluation system for consultants in January 2012. For the 16 major engineering, design and architectural projects we reviewed, the performance evaluation was not yet in effect and consequently the Department did not complete performance evaluations for the consultants assigned to these projects.

Use of Performance Evaluations to Assess Consultants Suitability for Future Projects

The majority of consultants are engaged through Direct Appointments or using a EOI. Neither of these processes uses consultant evaluations as assessment criteria. Not using the results from performance evaluations that the Branch has completed could result in the Branch engaging consultants with identified weaknesses, which increase the risk that the Branch will not receive the best value.

As the initial consultant engagement may not be based on a competitive, fair, open and transparent process designed to obtain the best consultant (weighing both technical capabilities and price), an evaluation could also indicate that the consultant may not have been the optimal choice had a competitive, fair, open and transparent system been used to engage the consultant initially.

Finding

12. The Department does not use performance evaluations that have been conducted to assess the suitability of a consultant for a future project.

Recommendations

1. The Department should comply with the *Guidelines Covering the Hiring of External Consultants:*

   - for engaging consultants on capital projects, and

   - obtain Treasury Board approval to authorize payments to consultants that are in excess of 110%, in the aggregate, of the approved original contract amount.

2. The Department should continue to complete performance evaluations and use the results of those evaluations to assist with the selection of consultants for future projects.

Department Response

Recommendation

1. ***The Department should comply with the Guidelines Covering the Hiring of External Consultants:***

   - ***for engaging consultants on capital projects, and***

   - ***obtain Treasury Board approval to authorize payments to consultants that are in excess of 110%, in the aggregate, of the approved original contract amount.***

Response

The Department appreciates the input of the Auditor General on the use of external consultants and acknowledges the recommendations contained in the report. The Department is reviewing the recommendations and will work to enhance the current process.

The Department has a long-established practice for engaging consultants. This practice is as follows:

- *The Department maintains a Consultant Registry which is regularly updated as consultants register throughout the year;*

- *Department officials, who have the experience and knowledge of the services that are available in the market, will assess the expertise, experience and qualifications of consultants listed on its Consultant Registry;*

- *Officials will undertake a review of the service required and the consultants who can meet the requirements;*

- *Based on that review, officials develop and bring forward to the Minister of Transportation and Works a list of consultants that are best qualified to perform that work; and,*

- *A selection is made by the Minister based on the list of consultants provided.*

In addition, Requests for Expressions of Interest are also used to identify consultants who can meet the requirements. As well, Requests for Proposals are used when the expertise required for a particular project is not available through the Consultant Registry.

In cases where the amount ultimately paid to a consultant has been in excess of 110% of the initial contract amount, the Department notes that its use of change orders in this regard ensures the full scope of a project is completed in the most timely and cost-effective manner. The initial contract cost is usually for preliminary work, often to determine the extent of an issue, and the nature of the work that will be required. Once the preliminary work has been completed, to expedite the process and contain project costs, the Department continues the project with this consultant through the use of change orders.

The Department is committed to openness and transparency. The Department welcomes the recommendations of the Auditor General and will immediately engage with the Department of Finance with a view to enhancing current processes.

Recommendation

2. The Department should continue to complete performance evaluations and use the results of those evaluations to assist with the selection of consultants for future projects.

Response

The Department of Transportation and Works will continue to complete performance evaluations and develop a formal process of applying the performance evaluation results in the selection of consultants for future projects.