STANDING COMMITTEE ON PUBLIC ACCOUNTS

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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Mr. Rob Norris
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Mr. Randy Weekes
Biggar

Mr. Trent Wotherspoon
Regina Rosemont

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[The committee met at 09:00.]

The Deputy Chair: — Good morning everyone. My name is Paul Merriman, and I'm sitting in as Chair while Ms. Chartier is going to be joining us later on this morning . . . [inaudible interjection] . . . And yes, Mr. Wotherspoon, I will be fair.

I just want to introduce the members. We have Mr. Doke, Mr. Weekes, Mr. Michelson, Mr. Norris, and Mr. Wotherspoon. And just to introduce some of the officials from the Provincial Comptroller's office, I have Terry Paton and Lori Taylor. Also like to introduce Acting Provincial Auditor Judy Ferguson. And I will turn it over to Mr. Hendricks, and if I could get you to introduce your officials and state their name and their position for Hansard, I would certainly appreciate it.

Mr. Hendricks: — Thank you. There are several ministry staff with me here today to answer specific questions in the report. To my left is Dawn Skalicky-Souliere, the director of licensing with community care branch. And to my right is Marsha Munro, the manager of the revenue and audit division. Behind me I have Tracey Smith, assistant deputy minister; Mark Wyatt, assistant deputy minister; Kimberly Kratzig, assistant deputy minister; and Karen Lautsch, also assistant deputy minister. We also have with us today Robbie Peters who is the vice-president and chief financial officer of the Regina Qu'Appelle Health Region; Nelish Kavia, who will be joining us I think, who is the vice-president of the Saskatoon Health Region; and John Knoch, vice-president from Sun Country Health Region.

The Deputy Chair: — Thank you, Mr. Hendricks. I'll get the Provincial Auditor to introduce her officials, and then we'll go through the agenda items.

Health

Ms. Ferguson: — Good morning. Thank you, Mr. Chair. Committee members and officials, with me today I've got Ms. Tara Clemett. Tara led the work that's before us right away here this morning. And behind her is Ms. Kim Lowe. Kim's our committee liaison and also actually works within the Health portfolio too.

So this morning the very first topic item that we're going to be dealing with is the two chapters: 2012 report volume 2, chapter 34 and chapter 48 out of the 2012 report volume 2 also. Tara's going to be presenting the results on those two chapters.

Before I do that, I just want to pause though and acknowledge and thank the ministry staff for their co-operation that was extended to our office in the course of this work here. So without further ado, I'm just going to turn it over to Tara to present the results in the two chapters.

Ms. Clemett: — Chapter 34, beginning on page 295 of the 2012 report volume 2, reports the results of the audit relating to the Ministry of Health's regulation of personal care homes, and chapter 48, beginning on page 377 of our 2014 report volume 2, reports the results of the follow-up on the related recommendations. I will present both chapters together.

In Saskatchewan the options available to seniors who need help to care for themselves vary according to their needs. While living in their homes they may arrange, through the regional health authority, home care; through private services, meals, household cleaning and/or personal hygiene assistance. As individuals require more help, they move to publicly funded long-term care homes or privately operated assisted living facilities or personal care homes. The government does not regulate or fund assisted living facilities for seniors. It regulates both long-term care homes and personal care homes.

Personal care homes are mostly privately funded. They provide accommodations, meals, and personal care to residents for a fee ranging from 1,000 to $4,000 a month. The Ministry of Health is responsible for setting licensing requirements and standards for personal care homes, including the training required to provide safe care. The ministry is also responsible for inspecting personal care homes to ensure that they meet established standards.

In 2011-12 Saskatchewan had 245 licensed personal care homes with just over 3,200 beds. As noted on page 298, the objective of our audit was to assess if the ministry had effective processes to regulate personal care homes in accordance with *The Personal Care Homes Act, 1991* and regulations for the period from April 1st, 2011 to August 31st, 2012.

We concluded the ministry did not have fully effective processes to do so and made five recommendations. First on page 301, we recommended the ministry use a risk-based approach to inspect high-risk personal care homes more frequently. We made this recommendation because the ministry had not developed a plan outlining homes that should be inspected more frequently based on risk.

On page 378 of our 2014 report volume 2, we report that the ministry has implemented this recommendation. Effective April 1st, 2014, the ministry began using a risk-based approach to determine the frequency of inspection using the numbers of compliance deficiencies and the number of complaints as criteria.

Second, on page 301 we recommended the ministry provide guidance to its staff to assist them in determining when to conduct unannounced inspections of high-risk personal care homes. We made this recommendation because the ministry's policies required staff to inspect personal care homes regularly but did not specify directly when staff should conduct unannounced inspections. In absence of such direction, staff might not assess the risk consistently in determining when unannounced inspections may be required.

On page 378 of our 2014 report volume 2, we report that the ministry has implemented this recommendation. The ministry requires staff to do an unannounced inspection of high-risk personal care home if the licensee has not submitted a report on required actions within 60 days or when an inspector determines the issue is best assessed through an unannounced inspection.

Third, on page 302 we recommended the ministry provide guidance to staff for consistent and prompt follow-up of personal care homes that do not comply with actions required

after inspections. In 2012, we found the ministry used informal discussion to guide staff when they should follow up on problems where personal care homes do not comply with actions and standards. Without formal guidance, staff may handle a similar problem differently. We think similar problems should result in similar required actions within similar timeframes.

On page 379 of our 2014 report volume 2, we report that the ministry has implemented this recommendation. It provides staff with written guidance setting out type and timing of follow-up expected when they find deficiencies during inspections.

Fourth, on page 303 we recommended that the ministry use a system to track personal care home inspection dates, non-compliance issues, required actions, and dates the personal care homes complete these actions. We made this recommendation because using a paper-based system to regulate about 245 personal care homes is challenging to staff to track all of the required actions resulting from inspections. Tracking actions is important because required actions can range from minor issues to important actions critical to protect resident safety.

On page 379 of our 2014 report volume 2, we report that the ministry has partially implemented this recommendation. At September 2014, the ministry electronically tracked inspection dates by manually tracked non-compliance issues, required actions, and dates of completion of the required actions. The ministry was working with the software suppliers to implement a more efficient data management system, and it expected the system to be operational in late 2014.

Fifth on page 304, we recommended the ministry publicly report inspection results when personal care homes do not comply with *The Personal Care Homes Act*. We made this recommendation because such public reporting would help residents and their families to better monitor the care personal care homes provide and help them make more informed decisions.

On page 380 of our 2014 report volume 2, we report that the ministry has implemented this recommendation. On March 28, 2014 the ministry created the personal care homes reporting regulations to allow for public reporting of inspection results. Since April 14th, 2014 the ministry has posted on its website the most recent personal care home inspections for each home.

In summary we are very pleased to report that the ministry took this audit very seriously and made excellent progress in addressing all of our recommendations. As reported in chapter 48 of our 2014 report volume 2, by September 2014 the ministry had implemented four out of the five recommendations and made good progress on implementing the last recommendation. That concludes my presentation.

The Deputy Chair: — Thank you very much, Ms. Clemett. Mr. Hendricks, if you could respond to each one of the recommendations directly.

Mr. Hendricks: — Well I would thank the auditor for her very detailed explanation of the findings. We too are very pleased with the progress that has been made on these recommendations.

As the auditor noted, with respect to four recommendations in chapter 34 and 48, we are now in compliance with those recommendations: specifically that the Ministry of Health use a risk-based approach to inspect high-risk personal care homes; secondly, that the Ministry of Health provide guidance for its staff to assist in determining when to conduct unannounced inspections at high-risk personal care homes; third, that the Ministry of Health provide written guidance to staff for consistent prompt follow-up of personal care homes that do not comply with actions required after inspections; and last, that the Ministry of Health publicly report inspection results when personal care homes do not comply with *The Personal Care Homes Act* of 1991.

As noted, there was one outstanding recommendation that the Ministry of Health use a system to track personal care home inspection dates, non-compliance issues, required actions, and dates for personal care homes to complete these actions.

The ministry tracks personal care home inspection dates electronically. It tracks non-compliance issues, required actions, and the date that the care home completes its required actions in paper files. We're currently working with a software vendor to have an electronic system in place for tracking these as well, and that should be in place by June of 2015.

The Deputy Chair: — Thank you, Mr. Hendricks. I open up the floor to the committee for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well thanks, first of all, to the auditor's office and as well to the ministry officials for their work on these important recommendations. Certainly it's an important body of work and has an impact directly on those that are in care.

I just want to touch on a couple of these pieces. First off the risk-based approach regarding inspections, and if you could just substantiate a little bit as to what that protocol looks like. Certainly I think it's wise when dealing with these matters to be dealing with things in a risk-based approach, but maybe just describe that protocol a little bit.

Mr. Hendricks: — I'll start and then maybe Ms. Skalicky-Souliere can add to my comments. So on April 23rd, 2014 the ministry began using a risk-based approach to determine the frequency of inspections. It uses the type of severity, either high-, intermediate-, low-risk deficiencies, and the number of compliance deficiencies, the number of founded complaints as criteria in determining the frequency of inspections.

Testing of inspections in 10 personal care homes, I think which was validated by the auditor, confirmed that the ministry's new use of this new risk-based approach was actually effective.

Mr. Wotherspoon: — Thank you very much. And could you just explain what would be sort of the high-risk environments?

Ms. Skalicky-Souliere: — A home that would display a high-risk deficiency, and a high-risk deficiency is defined on

the tools. So if the consultant answers no to this particular one — for instance, a home that's not open for inspection, the operator won't, is reluctant to let the official in to do an inspection — we would consider that high risk right away and other actions would be taken. But the other way it would become a high-risk deficiency is if it was a repeat. So if this was an issue last year and it's an issue this year, we consider it high risk right away. So that puts you into the higher risk category or a category where we would do more frequent monitoring.

The other thing we consider is how many deficiencies there are. So if there are three or more deficiencies, then we would view you as a home that we would need to monitor more frequently. And the other thing is if there was a founded complaint sort of between the last inspection and this inspection, that too would tell us that we need to monitor the home more frequently.

[09:15]

Mr. Wotherspoon: — As far as complaints, what's the best avenue for the public to bring forward concerns or complaints regarding the care in a specific care home?

Ms. Skalicky-Souliere: — Well they would contact our office, the personal care homes program. And we have an individual in our Saskatoon office who is responsible for carrying out the investigation of complaints in the northern homes, and we have an individual in the Regina office who's responsible for carrying out that function in the southern part of the province.

Mr. Wotherspoon: — Often people connect, but they're concerned with potential ramifications within the environment itself in disclosing or connecting with the system. Maybe can you just lay out what protections are in place to ensure, if someone's bringing some information forward, that the person in care that maybe they have concern over is protected and safe, and just how are you able to separate those duties?

Ms. Skalicky-Souliere: — Well I guess depending on the circumstance, if a complaint comes in about a particular resident, the consultant will go out and do an inspection of the home. They'll randomly look at records. Of course they'll look at that record in a bit more detail to determine, you know, what is there. If there's some evidence to support the allegation, certainly more digging will happen, maybe interviews with residents, interviews with family members, with other health care providers, that sort of thing.

But at some point in time, the consultant does sit down with the licensee and they say, you know, this has come to our attention, these issues. We've found some validity here, some problems here, and we need to talk about how those can be rectified, or tell us if what we've got here isn't correct. And so we always try and approach it with, let's focus on the root of the problem as opposed to who might have called, although the operators, if we do end up taking action against a particular operator, they do have right to understand what the allegations are against them.

Certainly during that whole process, if we believe a particular resident may be vulnerable, given the circumstances, then we would take certain steps to ensure that that resident is protected because that is the purpose of the Act.

Mr. Wotherspoon: — Okay. So maybe just on that note, and it's an important one, if the resident is potentially vulnerable if a complaint has come in and if there's a feeling sometimes by a person who may wish to bring forward a complaint that it may place the resident in a vulnerable position, is there a standard protocol on how you do some follow-up and some monitoring to make sure that that resident is being protected throughout that process and beyond?

Ms. Skalicky-Souliere: — Yes. If we were concerned about a particular resident, we would go out and visit the home a lot more frequently. We would also certainly talk to the family members, the supporters of the resident. And in extenuating circumstances, we would even work with the resident, their family, and the health region to find a more suitable place for them.

Mr. Wotherspoon: — Is there a standard process for that? If it's deemed I guess from the perspective of health, if there's a potential for that person to be vulnerable, is there an automatic check-in process with family and with that resident once a complaint has come in to ensure that person, that resident is being treated in a safe and protected manner?

Ms. Skalicky-Souliere: — I'm sorry. So after the investigation?

Mr. Wotherspoon: — After a complaint may come in and you're dealing with it, is there an automatic process that you would be checking in with family and the resident to ensure, or some monitoring of making sure that their treatment is appropriate, fair, and safe?

Ms. Skalicky-Souliere: — If the complaint was founded. And we don't arrive at that. If it's a treatment situation for instance, we would send out supporter interviews typically to supporters of many of the residents. Depending on the size of the home, we might randomly pick out 40 in a home of 100 for instance, and we would get some information that way.

We would certainly interview the residents. We would certainly interview the staff. We would make pop-in visits so that we can see who's working and how the interactions are going and that kind of thing. And yes, as we're popping in doing unannounced visits, we would pop in to that resident but not that resident alone, a couple of other residents too because you don't want to draw attention to one particular person.

And so during the course of that investigation, we gather all of that information and then we review it. And if there's some evidence to suggest treatment is not . . . for instance a particular staff person maybe not be interacting appropriately with a resident. Then we would take steps with the licensee and say, this is a bit of a problem. And depending on what is happening, it might be you need to ensure that this person gets some sensitivity training or some more training in communication skills. It could also be this resident cannot provide assistance or supervision with care to residents and cannot be left alone in the home. If you want to hire them to shovel the walks, that's fine, but they're not to provide care.

Mr. Wotherspoon: — Thanks. It's a really important area to make sure that the protection is in place. And I know there's a

concern sometimes of individuals, when they're looking at the issue, whether or not the person they care about in care, whether or not they're putting them at risk in bringing something forward. So thanks for describing a bit of that process.

You talked about having three or more deficiencies that would cause the risk to be elevated to the high level. Could you describe the types of deficiencies, the different sort of categories of deficiencies that Health's looking for?

Ms. Skalicky-Souliere: — Sure. If you don't mind, I'm just going to grab my little report here.

Mr. Wotherspoon: — Sure.

The Deputy Chair: — If I can just interrupt for just one second. The Acting Provincial Auditor would like to have a comment on this last conversation.

Ms. Ferguson: — I just wanted to draw to your attention that the original audit in 2012, we did look at their system for complaints and, you know, it's part of actually page 304. And when we looked at it, it was working as management has described it. So it's an area that we did look at in the course of that original audit, and we didn't find any problems.

Mr. Wotherspoon: — That's good. It's an important area.

Ms. Skalicky-Souliere: — Some examples of some issues could be something like they haven't posted the rights and privileges for residents in the home or any of the rules. For instance, you know, maybe certain homes don't allow alcohol in the home for their own . . . So they have to make sure that they communicate that to the residents before they make a decision to move in the home. They know that this home, you know, doesn't allow alcohol. So sometimes they may not have the rules posted so they're visible to the residents and the public.

Another example might be maybe the resident records because one part of the operational review is they randomly select resident records, and they go through them from beginning to end, from assessments to care plans, making sure that there's doctor's orders for the medications the residents are taking, all of those sorts of things. So it could be that maybe they didn't document something properly. Maybe they didn't . . . So that could be another example that would be a no when they look through the records.

Mr. Wotherspoon: — The deficiencies, are these the categories that are set and established that Health is . . . Do you have a listing of the deficiencies, the standard ones, that are noted by Health, or is this a fluid thing?

Ms. Skalicky-Souliere: — Well they're according to the requirements under *The Personal Care Homes Act*. The way the tool is structured is there's a couple of questions under licence. You have to have it posted, that sort of thing, and you're complying with the conditions and terms. Inspection is another piece, so the home is open to inspection. That's another example, and that all the records pertaining to the operation of the home is also open to inspection. The operator's not concealing them from the consultant when they go in.

The requirements of licensees, they've got somebody designated to provide appropriate oversight of the home. That would be another section. Are they meeting the requirements under that? Another section is records respecting residents. Are those all in place? What are some deficiencies? If there are some things missing or not quite right, they'll get a no.

Mr. Wotherspoon: — And if there's three of these, then it's treated at a higher risk. Within the actual deficiencies, are there are some categories that are deemed as a greater significance or higher risk in and of themself ?

Ms. Skalicky-Souliere: — Well I think the one that I had mentioned earlier about the home being open for inspection, that is one area that we would view as very high risk. If you're not leaving your home open to inspection, which you're required to do, it leads one to wonder what the reasons are, and then certainly in our view that would be a higher risk.

You know, we really like to take the approach of coaching. I mean there are a lot of requirements to meet, and our staff really like to try and support the licensees in meeting those requirements. And so when there is a no, there is a little bit of coaching that goes along too because the objective is for them all to meet all of the requirements next time we go in to do the inspection.

Mr. Wotherspoon: — So there's 245 licensed care homes I believe referenced in figure 1 on 297. Do you have the numbers as to how many homes were deficient at some point, you know, say for the previous year? Over the past year?

Ms. Skalicky-Souliere: — What I can tell you is, as of yesterday, there were, out of the 242 homes — and that number changes from day to day as homes open and close — 43 per cent of the homes had no deficiencies at inspection; about 39 per cent had deficiencies that had been addressed; and about 18 per cent of the homes had one deficiency that is currently unaddressed.

Mr. Wotherspoon: — And how many would have more than one?

Ms. Skalicky-Souliere: — I don't have that at my fingertips at this moment.

Mr. Wotherspoon: — So when the inspection occurred, 40 per cent . . . And how many of those homes . . . So were all those homes inspected? Do you inspect every home in a year?

Ms. Skalicky-Souliere: — Well that's part of the risk-based approach that we're using. Some of the homes that require our attention more often would get an inspection once a year at least, and those homes that are meeting the criteria could have a licence for up to two years, and that would mean that the inspection would occur every two years. But if there is a complaint after that and that complaint is founded, when we get out to do that next inspection, they will not be granted a two-year.

Mr. Wotherspoon: — So the percentages are good. Do you have the hard numbers as far as the number of inspections or homes that were inspected so we can have a better

understanding of what the 39 per cent is? For example how many homes were inspected that were then found deficient? And those were the ones that have now resolved it, I believe you've said, which is important.

Ms. Skalicky-Souliere: — There were 103 homes that make up the 43 per cent, so the 103 homes had no deficiencies. So if you go online and you look at the templates, you will see 103 of them don't have deficiencies. And 95 had deficiencies, but you'll see under the addressed column, yes, they were addressed. And there were 44 homes that still have deficiencies with no on it, so that means they're still working on them.

Mr. Wotherspoon: — Okay. Thanks. It's important information. I'm just looking at the second piece here about when an unannounced visit might occur, an inspection might occur. And there's the two circumstances that you've put in place, I believe, that the licensee hasn't submitted a report for 60 days, and then you have the personal care home consultant determines that an issue or a complaint is best assessed through an unannounced visit to the home. How often does that one occur?

Ms. Skalicky-Souliere: — In terms of numbers, I can't say. If a complaint comes up for instance and the complaint is around treatment of residents, it would make no sense to schedule a visit to go and see if the staff are treating the residents appropriately. You know, in that particular case, we would just want to just pop out on several different occasions at different times of the day to try and sort of get a sense of the different staff members and how they're interacting and those kinds of things in addition to the supporter interviews and that sort of thing. So that would be an example where an unannounced visit would really give you the best picture of what's going on there.

The other thing is how residents are maybe receiving their medications. If we have some concerns about that, going out there at a preplanned visit, you know, you might have your best, most seasoned staff member and those sorts of things working in the home, and we want to get a picture of what happens on a day-to-day basis. So that might have us go out unannounced.

Mr. Wotherspoon: — No, I think it's a very important tool to have, the unannounced visit. And I think that the flexibility that this piece offers is important.

So those are the two reasons that an unannounced visit could occur. What's the percentage breakdown as to the unannounced visits? How many are being caused, percentage-wise, based on the licensee not submitting the report in 60 days? And how many are or what percentage are occurring based on the personal care home consultant recommending that action?

[09:30]

Ms. Skalicky-Souliere: — I'm afraid I don't have those numbers with me.

Mr. Hendricks: — We can provide those.

Mr. Wotherspoon: — Sure. If you're able to provide it back to committee, and if you're able to provide I guess both the percentage then, and then as well the hard numbers of what that represents.

The Deputy Chair: — Are there any further questions from the committee? Mr. Norris.

Mr. Norris: — Great. Thanks very much. On 3.1, as it manifests itself in chapter 48 but it takes place before that as well, just want to get a sense on the risk-based approach and the progress that's been made. Two things: what were the approaches that were used previously and as part of this transition? I'm just trying to get a sense of how smoothly that's rolled out.

Ms. Skalicky-Souliere: — Well I think it's more it was dependent on when the consultant went out to the home, did the inspection, or did the complaint. It was more about do I need to, based on the outcome of my visit here, do I need to get a more real picture of what's going on here? And some of the examples I just shared about, so then they would go out.

So it's more the second piece that, you know, if the consultant determined that the situation was such, they would go out and do an unannounced visit. And of course with the changes we've made, we've said, well that stays, but we also have something more clear. In addition to that, if they don't follow up on their action items with you, we need to do an unannounced visit.

Mr. Norris: — Thank you.

The Deputy Chair: — Thank you, Mr. Norris. Mr. Wotherspoon.

Mr. Wotherspoon: — One last little area before we conclude, and that's just the area of protective services attending to homes. Do you keep track of the number of visits where protective services have been called to support with a fall or a lift within the homes?

Ms. Skalicky-Souliere: — We follow the requirements under *The Personal Care Homes Act*, which is making sure that the licensee carries out the services they provide according to those requirements with the goal of providing safe and adequate care to the residents in their home. And so the requirements under the Act guide us in that work. There are certainly other things that come up from time to time in various communities that we try and facilitate those conversations if there's issues that arise, but they don't necessarily fall directly within the requirements of the Act.

Mr. Wotherspoon: — Okay. Do you keep track of the number of, like do the licensees report the number of calls that they're having protective services attend to the home to assist with lifts of someone? I understand that sometimes fire is brought in if somebody's slipped off of the toilet and if they don't have the adequate staff to lift that person back into an appropriate safe place.

Ms. Skalicky-Souliere: — We do have serious incident reporting. And so the licensee is required to, if a serious incident occurs, and we define that in the regulations, they are required to submit a serious incident report to us. And the consultant would review that report to see if the appropriate follow-up was done. If it wasn't, they would follow up with the

licensee and provide some more direction around what follow-up needs to occur.

Mr. Wotherspoon: — So some of these probably wouldn't be serious incidents. Some are assisting with lifts that I understand some of, lots of the calls are coming in to protective services, that wouldn't be reported back. You wouldn't have numbers to track the number of calls of where protective services are responding to these homes. Is that correct?

Mr. Hendricks: — So I believe this issue came up in either estimates or last time we were . . . probably in estimates, where protective services was being called to assist with certain lifts, that sort of thing, or issues that were happening during lifts. I believe that we checked into that to see how frequently that was actually happening, there was a couple of situations, and provided that feedback to the committee. But I can check to see, because we did actually follow up and see how often that was happening.

Mr. Wotherspoon: — Okay.

Mr. Hendricks: — I would presume we would have written to the Chair of the committee, but we can verify that.

Mr. Wotherspoon: — Okay. But it's not something that's tracked by Health directly when a licensee's calling protective services to attend to the home? I know, and this might not be the correct assumption, but I know some in protective services and fire services would feel that these calls are becoming more frequent. And I think that there's a concern that in many cases they're there to assist with the lift because the staffing ratio or complement may not be appropriate to support that activity.

So I'm just not sure if this is something that's been tracked, and then the reason why that call was made and how that may connect to staffing levels or what other factors are contributing to those calls.

Ms. Skalicky-Souliere: — When we had further discussions with the consultants in the Saskatoon office and the fire protective services, we had learned from fire protective services that many of those calls, some were coming from personal care homes, but the majority of them were not coming from personal care homes. They were from other settings like assisted living or other settings that aren't licensed as personal care homes. And so we have met with them, our officials have met with them, and they are trying to work out a process so the licensees and others in the community understand what the protocol is if a resident falls and they do need assistance.

Mr. Wotherspoon: — Yes, it just seems that it might be important information to be tracking as well. I mean it's certainly anecdotally I'm hearing that there's some pressures in the community on this front and some suggestions as to what the factors might be to be contributing to those calls. But it seems that you're . . . It's sort of on your radar, and it would be an area that it'd be interested in seeing some further work on into the future. Otherwise I think I've satisfied my questions from this chapter.

The Deputy Chair: — Thank you, Mr. Wotherspoon. Seeing that we have two chapters in front of us, if I can get a . . . Could somebody please tell me what the wish of the committee is? Mr. Norris.

Mr. Norris: — Great. Thanks very much, Mr. Vice-Chair. If I could, we'd propose that we'd separate issues on chapter 34 from chapter 48, and if we go with chapter 34 first, then we would look at 1 through 3 and 5 in one heading. And what I'd suggest is that we concur with the recommendation and note compliance for those.

The Deputy Chair: — Thank you, Mr. Norris. So for the 2012 report volume 2, chapter 34, I have a recommendation of 1, 2, and 3, as well as 5, and the recommendation is that they concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Thank you. Mr. Norris.

Mr. Norris: — Great. Thank you, Mr. Vice-Chair. What I would then recommend is that again looking at chapter 34, we'd focus on the fourth recommendation, and we would concur with the recommendation and note progress towards compliance.

The Deputy Chair: — Thank you, Mr. Norris. So for the 2012 report volume 2, chapter 34, recommendation no. 4, the motion is to concur with the recommendation and note progress towards compliance. Is this agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Great. Carried. Thank you, Mr. Norris. And if I can get a motion to conclude considerations on chapter 48, that is the 2014 report volume 2, chapter 48, if I could get a motion to conclude considerations. Mr. Norris.

Mr. Norris: — Thank you, Mr. Vice-Chair. I would be happy to bring forward the motion of concluding consideration for chapter 48, especially given that the work has been undertaken really with alignment of chapter 34.

The Deputy Chair: — Thank you, Mr. Norris. I have a motion for the 2014 report volume 2, chapter 48 to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

Regina Qu'Appelle Regional Health Authority

The Deputy Chair: — Great. Carried. Thank you. And moving on to the next section, I don't know if we need time to adjust the officials, Mr. Hendricks? Are we . . . we've done the shuffle? Perfect. Then we'll move on to the next agenda item, which is the Regina Qu'Appelle Health Authority. We have four chapters covering three different years. And if I could get the Acting Provincial Auditor to go through, I believe we have chapter 18 from volume 2 of the 2012 report first. I'll turn it over to Ms. Ferguson.

Ms. Ferguson: — Thank you very much, Mr. Chair, committee members, and officials. Before we launch into our presentation, I just want to pause and reintroduce Ms. Lowe here. Ms. Lowe is actually responsible for our audit of the authority in addition

to being the liaison for this committee. And once again I want to just thank you and pause to thank the officials of the authority in terms of the co-operation extended to our office.

So this morning the agenda focuses on four chapters related to the Regina Qu'Appelle Authority. Chapter 2 from the 2013 report volume 1 contains the results of our audit of the authority's processes used to prepare its 2013 budget and its financial reports. This chapter contains six recommendations. They're new for the committee's consideration, and we incorporated the status of these chapters into our annual 2014 audit.

Chapter 18 from our 2012 report volume 2 and chapter 18 from our 2013 report volume 2 and chapter 18 from our 2014 report volume 2 — we seem to like chapter 18 for Health, I don't know why; I mean the health authority here — they each report the results of our annual integrated audits for those three years: March 2012, March 2013, and March 2014 respectively. Those chapters do not contain any new recommendations. So there's only new recommendations in that one chapter, chapter 2. So I'm going to turn it over to Kim to present the results of those chapters. Thank you.

Ms. Lowe: — Thanks. I will focus my comments on the recommendations in chapter 2 of our 2013 report volume 1 and chapter 18 of our 2014 report volume 2. Chapter 2 of our 2013 report volume 1 reports the results of our work that the Ministry of Health requested us to do at the authority. In January 2013 the ministry asked us to examine the processes the authority used for the 2013 budget preparation and financial reporting. The ministry asked us to do this work because during 2012 the board received and reviewed incomplete, incorrect, and untimely monthly projected year-end results. In November 2012 the board raised concerns about the large projected annual deficit compared to the budgeted surplus in the approved budget. We made six recommendations to help Regina Qu'Appelle improve its processes.

First, on page 32 we recommended the board of Regina Qu'Appelle review and approve future budgets on a timely basis. We made this recommendation because the board received and approved the final 2013 budget on May 28th, 2012, two months after its year-end of March 31st. The 2013 budget showed that Regina Qu'Appelle expected to have a $2 million surplus at March 31st, 2013.

By May 2012, when the board approved the budget, Regina Qu'Appelle had already started to fall behind on financial targets outlined in the budget. Financial reports for April and May 2012 showed the accumulated operating deficit of $5.1 million and $7 million respectively, and in June 2012 Regina Qu'Appelle projected a 2012-13 year-end deficit of $9.3 million. In December 2012 the projected year-end deficit increased to $24 million. The large size of deficit raised questions as to whether cost-saving initiatives and operating efficiencies set out in the budget were achieved.

On page 110 of our 2014 report volume 2, we report that by March 2014 the board has made progress to implement this recommendation. The board received interim plans before the beginning of the year. It improved the timing of its approval of the direction for 2014-15 financial planning to March 2014. To provide management with timely direction, boards should review and approve budgets before the beginning of its fiscal year. It can revise its budget as necessary when the funding from the Ministry of Health becomes known.

Second, on page 33 we recommended Regina Qu'Appelle provide the board reliable monthly financial reports that include reasonable and supportable projections of year-end results. We made this recommendation because the 2012-13 financial reports that management gave the board had incomplete information about the projected year-end results and incomplete reasons for differences between the actual and budgeted operating results.

On page 111 of our 2014 report volume 2, we report in section 4.3 that Regina Qu'Appelle has not yet implemented this recommendation. Management needs to further improve the projection that it provides to the board. In our review of some monthly 2013-14 financial reports, management could not provide a support for the projected deficit included in those reports or explain why the projected deficit differed significantly from the actual results.

[09:45]

Third, on page 33 we recommended Regina Qu'Appelle include in its monthly reports to the board complete reasons for differences between the year-to-date budgeted and actual expenses. We made this recommendation because Regina Qu'Appelle did not provide reasons for differences between the budgeted 2012-13 expenses to date and actual 2012-13 expenses to date and reasons for overages. For example, differences between the budgeted salary expenses and actual salary expenses were not explained.

On page 111 of our 2014 report volume 2, we report in section 4.2 that by March 2014, Regina Qu'Appelle implemented this recommendation. During 2013-14 Regina Qu'Appelle included complete reasons for differences between year-to-date budgeted and actual expenses in the monthly financial reports that it gave to the board.

Fourth, on page 34 we recommended Regina Qu'Appelle develop action plans to address projected operating deficits and provide a formal plan to the board for approval. We made this recommendation because we found that Regina Qu'Appelle had not told its board on a timely basis how it planned to contain its growing financial deficit. In late 2012, management set up a committee to look into this, into how best manage the deficit. Through this committee, it established a strategy to reduce future expenditures.

On page 112, section 4.5 of our 2014 report volume 2, we report that Regina Qu'Appelle has not implemented this recommendation. While the board minutes and documents show discussion about deficits and deficit reduction strategy, Regina Qu'Appelle had not documented any formal plan to address projected deficits for the board's approval. For the year ended March 31st, 2014, Regina Qu'Appelle had an annual deficit of $9.6 million.

Fifth, on page 35 we recommended the board perform regular, timely, and thorough review of Regina Qu'Appelle's financial

reports. We made this recommendation because the board did not receive reports on a timely basis. For example, it received April 2012 reports in June 2012 and October 2012 reports in December 2012.

On page 112, section 4.4 of our 2014 report volume 2, we report that while the board received financial reports on a timely basis as previously noted, those reports were not adequate.

Sixth, on page 35 we recommended Regina Qu'Appelle request the ministry to appoint individuals to the board with financial expertise necessary to assess financial reports. We made this recommendation because we noted that the board did not ask management to provide reasons for clearly inconsistent projected year-end results when compared to actual operating results between June and December 2012.

Regina Qu'Appelle is a large organization with complex financial matters. To provide effective oversight over its finances, board members must collectively have adequate financial expertise. On page 112, section 4.6 of our 2014 report volume 2, we report that Regina Qu'Appelle has implemented this recommendation. In March 2014 the Chair of the board asked the ministry to appoint at least one board member with an accounting designation to help the board manage financial risk.

Chapter 18 of our 2014 report volume 2 includes three recommendations not related to our 2013 report volume 1. On page 113 we report Regina Qu'Appelle has not implemented one other recommendation that we made in 2008 relating to an internal audit function.

Regina Qu'Appelle is a large organization operating in multiple locations. Unlike other large Saskatchewan regional health authorities, Regina Qu'Appelle does not have an internal audit function. Such a function could provide management and the board with insight on the effectiveness and efficiency of its critical control processes.

Also on page 113, we report that Regina Qu'Appelle has partially implemented our 2009 recommendation related to prompt removal of user access to its information technology systems and data. In common with many other government agencies, we found that staff did not always remove unnecessary user access promptly.

Finally on page 114, we report that Regina Qu'Appelle has partially implemented our 2009 recommendation related to establishing an adequate disaster recovery plan and testing it. At March 2014 it did not have a complete disaster recovery plan.

In 2013 Regina Qu'Appelle implemented our past recommendations related to human resource planning. With respect to our recommendation related to regional health authorities having capital plans referred to in our 2012 and 2013 reports volume 2, chapter 18, we plan to follow up on the status of this recommendation and report on this in a future report. And that concludes my presentation.

The Deputy Chair: — Thank you very much, Ms. Lowe. If I could turn it over to the ministry officials, Mr. Hendricks, and if I could get your officials to introduce themselves just for the record of Hansard please.

Mr. Hendricks: — Okay. Robbie Peters from the Regina Qu'Appelle Health Region, the CFO [chief financial officer], has joined me at the front.

The order might be slightly different here. It went a little out of order compared to how I have my notes. But in chapters 2, 18, and 6, previously outstanding recommendations have been implemented, which was mentioned last by Ms. Lowe was the human resource planning. Regina Qu'Appelle has implemented that, analyzing the extent of its workforce gaps and estimating their future impact on service delivery and monitoring human resource risks at least quarterly using key performance measures.

The second one, "We recommend the Regina Qu'Appelle Regional Health Authority include in its monthly financial reports to the Board of Directors complete reasons for differences between the year-to-date and budgeted and actual expenses," we believe that has been implemented.

"We recommend that the Regina Qu'Appelle Regional Health Authority requests the Ministry of Health to appoint individuals to the Board of Directors with financial expertise necessary to assess financial reports," the region has complied with that directive. "We recommend that the Board of Directors of the Regina Qu'Appelle Regional Health Authority review and approve future budgets on a timely basis," again implemented.

"We recommend that Regina Qu'Appelle Regional Health Authority provide the Board of Directors reliable financial monthly reports that include reasonable and supportable projections of year-end results." That has been implemented. And we recommend that the board of directors of the Regina Qu'Appelle Health Region perform regular, timely, and thorough reviews of financial reports, again implemented.

There are five outstanding recommendations in the auditor's report: the internal audit recommendation that the Regina Qu'Appelle implement an internal audit function; the information technology recommendations, first that we recommend that the Regina Qu'Appelle Health Authority adequately protect its information technology systems and data, and secondly the health authority establish adequate disaster recovery plans and test those plans to ensure their effectiveness; in terms of board governance recommendations, that the Regina Qu'Appelle Health Authority develop an action plan to address projected operating deficits and provide a formal plan to the board of directors for approval; and lastly the capital plan recommendation that the Regina Qu'Appelle Health Authority should prepare a capital plan that contains all elements for capital plans in the public sector.

The region has made some progress on the outstanding audit recommendations. Those include internal audit. The Regina Qu'Appelle Health Region and board of directors have started preliminary discussions regarding the internal audit recommendation with a goal set for implementation of this position and this function within the 2015-16 fiscal year.

With respect to the IT [information technology], the outstanding IT recommendations, the region is also working with eHealth Saskatchewan and the Saskatoon Health Region to define its provincial data centre model, including a provincial disaster

recovery plan. The provincial data centre model is to have each data centre managed in an integrated manner which allows Regina to be the primary data centre and Saskatoon to be the recovery site.

On the item relating to board governance, the region has established an efficiencies target initiatives working group to lead several initiatives designed to manage projected operating deficits and to enhance the effectiveness of daily resource management.

And lastly, the capital plan. The region has recently created a capital oversight committee, and the oversight committee is expecting to complete both the development and implementation of a comprehensive capital equipment plan by June 30th, 2015.

I do have to commend the region on the many actions that they have taken since 2012 when we as a ministry did identify some troubling issues with respect to the financial reporting that was being submitted to the board of governors of the region. I'm feeling confident now that the board of governors, the board of directors is receiving the appropriate information that it needs to effectively monitor the region.

We do note that while the region has asked that the ministry appoint someone on the board of directors that has financial expertise, we're finding it a little bit challenging finding a person who is available and willing to serve on the board that would have that expertise. But we are committed to do so and are still kind of conducting our search of somebody who could fill that role. So again we are quite happy with the progress the region is making, and we feel like their controls are much more solid now.

The Deputy Chair: — Thank you, Mr. Hendricks. Open the floor for questions from the committee. Mr. Wotherspoon.

Mr. Wotherspoon: — I was having trouble just actually going back between the two chapters and keeping up with the recommendations, so forgive me if I'm asking a question that was provided in your statement there. And thank you to the good work of the auditors, and thank you to the work of all those involved to address these recommendations.

So I have within the report here, from chapter 18, there's some of these recommendations that were noted as partially implemented, but I believe you've identified here today that some of those have now been implemented. So is that correct around, for example, the regular, timely, and thorough reviews of financial reports by the board of directors? Did you suggest that that one is now fully implemented?

Mr. Hendricks: — We believe it is, yes. And so part of this is that this might have been implemented since the auditor did their last review, and it will be about coming in and verifying that.

Mr. Peters: — That's correct.

Mr. Wotherspoon: — So there's been changes made in the financial information that's being presented to make sure that it's fulsome and accurate and, you know, a form that's appropriate. What were the deficiencies with that information before in how it was being presented?

Mr. Hendricks: — I think there were a couple of deficiencies. First of all, I don't believe that the appropriate information was being shared with the board. I think that the information may have been not presented as factually as it should have been. Secondly I think, and this is something that we always have to watch with boards, is oftentimes they become very dependent on their management, and very trusting. You have to have people on the board of directors who are asking the right questions of the management. So they've developed standardized documents that they do provide the board that give the board the reassurance that they're seeing the complete financial picture. That I think, you know, we feel in having looked at those documents that they would allow a board to assess the condition, the financial condition of the region. I don't know if you want to add.

Mr. Peters: — I guess I would just qualify that I've been with the region for less than a year now but my understanding of the events back then were — and the auditors might be able to correct me if I go off track here — my understanding was that our internal finance department were preparing their projections for the rest of the year. Those were going to senior management. Management decided that we're going to take actions and take this down to a balanced budget. So that's what got reported to the board, I believe, without any real action plans that were going to get them there. Is that correct in terms of the discrepancies of them?

Ms. Lowe: — Yes.

Mr. Peters: — So now we are definitely, whatever our finance department is projecting, that's what gets shared with the board.

Mr. Wotherspoon: — No, thank you. We'll have to get some of those guys to give advice back to the Minister of Finance to make sure the same sort of reporting happens on his end, but we'll leave that for another committee.

Moving along to some of the other recommendations. The internal audit piece that's not . . . There's some progress on that front but that hasn't been implemented. Maybe if you can just speak to some of the risks of not having that function in place.

Mr. Peters: — Well I think the biggest risks and the benefits of an internal audit is to make sure that you're complying with your internal controls — your management, your financial management control, your information technology controls, just generally safeguarding of your assets. I think there's a real benefit to the audit committee or the board of directors to have an internal audit function. It gives them some further reassurance in terms of the controls that management has in place.

I think, you know, you can take from the recent reports from the auditor, there's not a lot in there in terms of internal control risks and concerns that they have. So I think, you know, there's really been nothing new identified in the last few years, so that would sort of suggest that that the controls in place are adequate.

[10:00]

Mr. Hendricks: — It would be my hope that if you have an effective internal audit function, and we have one in the ministry, that this could have helped to have prevented a situation like that that occurred in 2012. An internal auditor has a responsibility to report irregularities beyond the CFO and CEO [chief executive officer] if he or she feels that the region isn't complying with proper standards. And so in our case, our auditor can go around me or our CFO if she or internal audit feels that we're not complying with something. I think it's a good check and balance to have in the system, and I'm hoping that the region will have somebody soon.

Mr. Wotherspoon: — And do you have a timeline on this front to have internal audit function?

Mr. Peters: — The only timeline would be within the next fiscal year. We're at a very preliminary stage right now, assessing the different options and what the structure could look like.

Mr. Wotherspoon: — Are you confident that you'll have that function in place in the next fiscal year?

Mr. Peters: — I'm very hopeful, yes.

Mr. Wotherspoon: — The question here about appointing individuals with financial expertise to the board of directors or as directors, what's deemed as financial expertise?

Mr. Hendricks: — Like typically on a region of this size which has nearly $1 billion budget — and maybe the auditor wants to answer that — but from my perspective what we would be looking for is somebody that either has some accounting designation, that is a CA [chartered accountant], a CMA [certified management accountant], but also that experience on a board of directors and senior management and how to ask the right questions.

You can have somebody that has the proper financial accounting knowledge, but unless they understand the questions to ask and they feel comfortable asking those questions in a board setting, they won't be very effective. So typically what we would look for is somebody that had experience with a larger private sector corporation or a large public sector corporation that was familiar with board operations and good at kind of getting inside and asking management the appropriate financial questions to understand and be reassured that they're providing the proper and appropriate results.

So I know on the boards that I've served on in the past, that's what we look for. These are large, complex budgets, and you have to have that expertise on the board. There are people on the board with varying degrees of that, but I would say that it's a skill. When we look at the skill matrix of our boards, it's something that we would want to strengthen on the Regina Qu'Appelle Health Region board.

Mr. Wotherspoon: — Is that an issue on other boards as well from your perspective or the perspective of the auditors?

Ms. Ferguson: — I think really where we're at in the larger, other health authorities, they seem to be fine at this point in time. As always I think, you know, the board membership changes all the time, so I think it's a continued challenge that the ministry faces.

I just want to add too, like on the internal audit front and our view for this organization, particularly because they are having trouble having that financial acumen at the board table, I think it increases their need to have that internal audit function to assist the board in that area because it is an identified gap at this point, and so I think that again increases the need. And I do echo the deputy minister's comment that I really think that if an internal audit function was in place, some of the problems that we've identified here would not have occurred.

Internal audit functions also extend beyond financial too. They can assist in the IT area, which again, you know, may mitigate some of the problems occurring there, and also you'll find robust internal audit shops will also help in that operational aspect.

So this is a large, complex organization. They need those financial expertise. Internal audit could help on that. But I think really from your board question, it's really those main, like P.A. [Prince Albert], Saskatoon, and Regina that, you know, this one sticks out a little bit in terms of that financial expertise at the board level.

Mr. Hendricks: — I don't want to leave the committee with the impression that there's no financial expertise on the board. Lloyd Boutilier, the chairperson, is a licensed financial adviser that works for Royal Bank, Wood Gundy. Linda Jijian is a certified financial planner. Larry Miskiman who is also a member is an associate of the Credit Union Institute of Canada and has been a regional VP [vice-president] for Conexus Credit Union for many years. And then Judy Davis, the most recent addition to the board, of course has been with the Regina hospital foundation for many years. So it really is that kind of more dedicated accounting knowledge that we would probably be looking for.

Mr. Wotherspoon: — Thanks. I don't think I have any further questions at this point in time. But that internal audit function, I think those were important points added by the auditor there about the important check and balance within an organization, and it would be really important to see that established.

The Deputy Chair: — Thank you, Mr. Wotherspoon. Any other questions from the committee? Seeing none, as we've got four different areas over three different years, different chapters, if we could do the 2013 volume 1, chapter 2. I believe we have six recommendations, and if I could get a motion for those six recommendations. Mr. Norris.

Mr. Norris: — Great. Thank you, Mr. Vice-Chair. What I'll do is I'll propose that for chapter 2 we'll actually split it into two parts once again, and we'll have 1, 2, 3, 5, and 6 that the motion would read concur with the recommendation and note compliance.

The Deputy Chair: — Thank you, Mr. Norris. The motion is for the 2013 report volume 2, chapter 2, recommendations no. 1, 2, 3, 5, and 6 that we concur with the recommendation and

note compliance. Is that agreed? Sorry. There's a question. Mr. Michelson.

Mr. Michelson: — I'm sorry. Was no. 2 included in that? From my notes, I didn't think it was complied with.

The Deputy Chair: — I had noted Mr. Hendricks had said that they were in compliance with it now. Mr. Hendricks, maybe if you could just clarify or if we could get the Provincial Auditor . . .

Mr. Hendricks: — I believe the region felt that they were in compliance with that and I had said that the auditor . . . So our view is that it's implemented. The auditor can come out and have a look.

The Deputy Chair: — Thank you, Mr. Hendricks. The Provincial Auditor, maybe just a comment on it just to clarify for the committee.

Ms. Ferguson: — It's really just to echo what the deputy minister said. You know, we recognize that there's progress that can occur since the last time that we've looked. The end of our last look was at March of 2014. Obviously there's a passage of time since then, and we will be looking in the course of our annualized audit.

Mr. Michelson: — Thank you, Ms. Ferguson.

The Deputy Chair: — Thank you for that. So again I'll have a recommendation on the floor for the 2013 report volume 1, chapter 2, recommendations no. 1, 2, 3, 5, and 6. And the motion is that those recommendations concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Mr. Norris.

Mr. Norris: — Great. Mr. Vice-Chair, dealing with the same chapter 2, I would also offer a motion regarding chapter 4, and that is concur with the recommendation and note progress towards compliance.

The Deputy Chair: — Thank you, Nr. Norris. So I have a motion of the 2013 report volume 2, chapter 1, recommendation no. 4 is to concur with the recommendation and note progress towards compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. We have three other ones that we need to conclude considerations. We have the 2012 report volume 2, chapter 18, and if I could get a motion to conclude considerations. Mr. Norris.

Mr. Norris: — Yes. Thank you, Mr. Vice-Chair. For the 2012, chapter 18, indeed a motion will be concluding consideration.

The Deputy Chair: — Thank you, Mr. Norris. The motion is to conclude considerations on 2012 auditor's report volume 2, chapter 18. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. We have the 2013 report volume 2, chapter 18, if I could get a motion to conclude considerations. Mr. Norris.

Mr. Norris: — Thanks, Mr. Vice-Chair. Regarding chapter 18 from the 2013 report, again I would offer a motion concluding consideration.

The Deputy Chair: — Thank you, Mr. Norris. The motion is for the 2013 report volume 2, chapter 18. A motion is to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. We have the 2014 report volume 2, again chapter 18, if I could get a motion to conclude considerations on that. Mr. Norris.

Mr. Norris: — Great. Thanks, Mr. Vice-Chair. And as with the other two, for chapter 18 from 2014, I'd propose a motion concluding consideration.

The Deputy Chair: — Thank you, Mr. Norris. We have a motion for concluding considerations of the 2014 auditor's report volume 2, chapter 18. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Thank you very much to Mr. Hendricks, the officials, especially from the Regina Qu'Appelle Health Region, for coming today and presenting to the committee. Thank you again for working with the auditor's office and coming into compliance with a lot of recommendations. As it's been noted here, a very large organization, very many people in different areas of the region that are impacted by the great work that you are doing, so again thank you very much for everything you're doing and working with the auditor's office. And thank you for the auditor's office for providing the recommendations and the audit. We look forward to the next time that you're up for the Public Accounts Committee.

So with that, seeing if there's no other questions, that we will recess until 1 o'clock today to go over the Saskatoon Regional Health Authority. Thank you.

[The committee recessed for a period of time.]

The Deputy Chair: — Good morning again, everyone. As a committee we've decided that we have the officials in the room from the Saskatoon Regional Health Authority as well as the Sun Country, so I think we're going to proceed.

We've got a few chapters here to do with the Saskatoon Health Region, and we're going to break them up into four parts. On the agenda, the 2012 report volume 2, chapter 23; 2013 report volume 2, chapter 23; and 2014 report volume 2, chapter 25 will be the first part. So if I could get the auditor and the officials to conclude their comments in and around those three chapters, we will get things started. So at this time I'll turn it over to the acting auditor, Judy Ferguson.

[10:30]

Saskatoon Regional Health Authority

Ms. Ferguson: — Thank you very much, Vice-Chair, committee members, and officials. With me today that's joined me just now is Ms. Regan Sommerfeld. Regan's a principal with our office that's responsible for the various audits of the Saskatoon Health Authority that is before us this morning. And once again behind us is Ms. Kim Lowe who's the liaison for our committee and, as previously indicated, she also works on the Health portfolio. I just wanted to thank actually the Saskatoon Health Authority for the co-operation that they've extended to us in the course of those audits.

As the Vice-Chair just noted, we've got eight chapters. We're going to break the presentation into four parts, focusing on the first part that the Vice-Chair just noted. I'm going to present the first three parts, and then Regan's going to present the last part there.

So without further ado, I'm going to move to chapter 23 in both our 2012 report volume 2 and 2013 report volume 2, and chapter 25 in our 2014 report volume 2. These describe the results of our annual integrated audits for the three years March 31st, 2012, 2013, and 2014. Chapter 23, which begins on page 164 of our 2012 volume 2, this chapter is the one that includes a new recommendation and has a repeat of past three recommendations that your committee's already considered.

You'll see that, with respect to the repeat recommendations in a latter chapter, we do indicate that the Saskatoon Health Authority has implemented the IT point, and so I'm going to focus on the new recommendation that's included in this chapter.

So if you go to page 169 of the chapter, our new recommendation asks that the Saskatoon Health Authority establish a transparent process to select stakeholder presentation on advisory committees and make that process public. The recommendation resulted from our additional work to examine the reasonableness of the processes Saskatoon used to select the location of a new children's hospital.

Saskatoon used what it called a validation committee to obtain input from the public and physicians about the new location. We found that the committee used extensive independent expertise to decide the location; however, while the Saskatoon's process to select the members of the validation committee . . . we found that that process wasn't transparent. The process Saskatoon used to select a new hospital was, however, reasonable. On page 165 of our 2013 report volume 2, we report that Saskatoon has implemented this recommendation. It now has a policy setting out its process to select stakeholder's representation on any future advisory committees.

The remaining two chapters, chapter 23 of our 2012 report volume 2 and chapter 25 of our 2014 volume 2, just provides an update on the status of the other recommendations. And you'll note that there is progress on a number of those recommendations. And as I just indicated, they've implemented the recommendation with respect to security, IT security system and data. So that concludes our presentation on those three chapters.

The Deputy Chair: — Thank you, Ms. Ferguson. Mr. Hendricks, if I can again remind your officials just to introduce themselves, just for the records of Hansard. And if we could go through those three chapters on part 1, that would be great.

Mr. Hendricks: — Thank you, Mr. Chair. Joining me now is, Mr. Nelish Kavia who is the vice-president and chief financial officer of the Saskatoon Health Region, and we'll call on him probably in a minute.

As Ms. Ferguson said, we have three implemented recommendations across these chapters, or we feel that we do across chapters 23 and 25. Specifically we recommend that Saskatoon Regional Health Authority establish information technology policies and procedures based on threat and risk analysis. A threat and risk assessment was conducted by SHR [Saskatoon Health Region] in June 2010 and was revisited and revised in February 2014. So they believe that they are in compliance.

The second one is we recommended that Saskatoon Health Region establish an adequate disaster recovery plan and test the plan to ensure its effectiveness. SHR has established a disaster recovery plans for all production systems managed by the health region, and the backup and recovery of the processes have been tested for their effectiveness.

With respect to the third item, we recommended that the Saskatoon Regional Health Authority establish a transparent process to select stakeholder representation on advisory committees and to make that process public. As noted by Ms. Ferguson, this has now been implemented by the health region as well.

There is one outstanding recommendation which we would note progress on. We recommended that the Saskatoon Health Region should prepare a capital equipment plan that contains the key elements for a capital equipment plan in the public sector. The region has been working on developing the capital equipment plan with appropriate key elements, and it is expected to be complete in March 2015.

The Deputy Chair: — Thank you, Mr. Hendricks. Open to the committee for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well thanks for the report on the actions and the progress on these recommendations. Some of them that go back a little ways, and it's nice to hear that there's compliance in place on these recommendations. So that's good. Did I understand that, outside of the capital equipment plan which you have some timelines for, that the outstanding recommendations have been dealt with? Is that correct?

Mr. Hendricks: — Yes.

Mr. Wotherspoon: — Well that's positive, and thank you for that work.

The Deputy Chair: — Thank you, Mr. Wotherspoon. Any other questions from the committee? Mr. Norris.

Mr. Norris: — Great. Thanks very much, Mr. Vice-Chair. Just can we get a little bit more information on the capital equipment plan? There's progress under way. What are some kind of thresholds for you as far as success? What does that look like as you continue with your work?

Mr. Kavia: — Sure. Again just to introduce myself, I am Nelish Kavia, VP of finance and corporate services. In terms of the capital equipment plan, ideally what we would like to have in place is visibility of what our total equipment lifespan is and where each of those equipment pieces are. Some of the progress that we've made has been on our maintenance side as well. So we've been building a database of our capital equipment and understanding what the age and maintenance requirements are, and that really helps us drive our equipment needs ongoing.

So that will be the element of it. We're working with 3sHealth because we want to make sure we're looking at it from a provincial lens to understand what the current state is of the capital equipment plan, of the capital equipment needs. And that's part of what we're hoping to have done by March 31st.

Mr. Norris: — Thank you.

The Deputy Chair: — Thank you, Mr. Norris. If there's any other questions? Seeing none, if I can get a recommendation from the 2014 report volume 2, chapter 25. I believe we only have one recommendation. Mr. Norris. Oh I'm sorry, chapter 23, my mistake. Too many chapters, too many chapters 23. The 2012 report volume 2 chapter 23, we have one recommendation. Mr. Norris.

Mr. Norris: — Great. Thank you, thank you very much. And on that I would just like to note that the recommendation would be or the motion would be recommendation and note progress towards compliance.

The Deputy Chair: — That's fine, Mr. Norris. I believe it was in compliance, if that was correct from Mr. Hendricks as well as the Provincial Auditor. Okay. If we could get a new motion?

Mr. Norris: — Yes, absolutely, my apologies on the number. On that one, concur with the recommendation and note compliance.

The Deputy Chair: — Thank you very much, Mr. Norris. So on the 2012 report volume 2, chapter 23, on the one and only recommendation, the motion is to concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Agreed. Carried. We have the 2013 report volume 2, chapter 23. If I could get a motion to conclude considerations? Mr. Norris.

Mr. Norris: — Thanks very much, Mr. Chair. Happy to put forward the motion as far as concluding consideration.

The Deputy Chair: — Thank you very much, Mr. Norris. The motion is for the 2013 report volume 2, chapter 23 to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. We have the 2014 report volume 2, chapter 25. If I could get a recommendation to conclude considerations? Mr. Norris.

Mr. Norris: — Great. Thank you, Mr. Vice-Chair. Again on chapter 25 from 2014, the motion would be to conclude consideration.

The Deputy Chair: — Thank you very much, Mr. Norris. I have the 2014 report volume 2, chapter 25, the motion is to conclude considerations on that. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. I just wanted to take a moment here, just pause. I notice that we have some guests from the SLIP [Saskatchewan legislative internship program] program, and I just wanted to welcome you to the Public Accounts Committee. I hope that you enjoy what's going on. Please feel free to ask any of the elected members or any of the officials any questions that you have after the proceedings are finished. But welcome and thank you very much for attending, and I hope you enjoy the Public Accounts. Thank you very much.

In that I guess we will move on to part two. We have two separate years. We have the 2012 report volume 2, chapter 49 and we have the 2014 report volume 2, chapter 54. That'll conclude part two, and I'll turn it over to the Provincial Auditor.

Ms. Ferguson: — Thank you very much. In those chapters, these are both the follow-up chapters on protecting IT infrastructure. They actually follow up recommendations that we made in an audit in 2010, and there are six recommendations.

I'm going to focus my comments on chapter 54 of our 2014 report volume 2 in that that provides the most recent status of those recommendations. First off, just to remind the committee that Saskatoon Regional Health Authority uses and relies on its IT systems and services in the delivery of its health services. These systems include confidential patient data, including the results of lab results and medication imaging.

By August 2012, as reported in our chapter 49, we had noted that the authority had made good progress and that had implemented two recommendations and had made progress on the remaining. If you look on page 396 in section 3.1, we reported that it had implemented its policies to effectively manage its IT infrastructure, and on page 398 they had a complete disaster recovery plan that it recently tested and updated.

By September of 2014, which is in chapter 54, the authority needed to complete the implementation of its monitoring controls so that it can detect and address on a timely basis security attacks or potential breaches. It also needs to take steps to ensure it follows the established policies and procedures. And we noted that while it had implemented policies and procedures to update its servers semi-annually, staff did not consistently follow them, in that at September 2014 some network equipment was not kept up to date.

[10:45]

We also found that while Saskatoon had established a process to grant and remove user access properly, again staff did not always follow those processes. We noted 92 individuals who, while they were no longer employed by the region, continued to have access to its system and data.

So overall they made good progress, implemented some recommendations, and are making further progress on the outstanding ones. Thank you.

The Deputy Chair: — Thank you, Ms. Ferguson. Mr. Hendricks, I see that we've got two out of the five completed. If you could address the remaining three and just let us know a status update on those three recommendations, that would be great.

Mr. Hendricks: — I think we have four out of the six completed. Is that accurate, Ms. Ferguson?

Ms. Ferguson: — Yes, it is. Yes.

The Deputy Chair: — Sorry, my mistake.

Mr. Hendricks: — And so in terms of the two outstanding recommendations that Ms. Ferguson spoke to, we would agree with them that those are both in progress. With respect to the recommendation "that the Saskatoon Regional Health Authority configure and update its computers and network equipment to protect them from security threats," in July 2014 the region implemented a process to update and patch its server semi-annually.

It has assessed approximately 41 per cent of its servers to determine what work is required to fully update the equipment, and the work continues on that. A work breakdown for patching network equipment has been developed and executed in November 2014, but there's still work to be done to complete that.

As well with respect to the recommendation that the region "monitor the security of its information technology infrastructure," the region has approved policies for monitoring access to and use of IT systems and for managing IT security incidents.

IT completed work to lock and monitor access to all rooms that store computer equipment. Has been implemented. It began implementation of a central logging system to collect IT security data and is evaluating the potential use of additional systems to collect further data. It has hired an employee in October 2014 to focus on monitoring IT security to detect security attacks or potential breaches by analysing the data from these systems. So in our view, the region is in progress on this one.

The Deputy Chair: — Thank you very much, Mr. Hendricks. Is there any questions from the committee? Mr. Wotherspoon.

Mr. Wotherspoon: — Thanks for the update. Thanks for the actions to address the recommendations. Specific to the two that haven't yet been brought into compliance, what sort of timeline is the health authority looking at to address both of those?

Mr. Hendricks: — The patch, if required, is to be completed by May 2015, and the IT infrastructure in terms of the security breaches, to protect against potential breaches or attacks, is to be complete by January 31st, 2015, so by the end of this month.

Mr. Wotherspoon: — Thanks. It's important work, and we appreciate the progress on it.

The Deputy Chair: — Thank you, Mr. Wotherspoon. Any other questions from the committee? As these have been reviewed before, there is no voting on it. We just have to conclude consideration. So we have the 2012 report volume 2, chapter 49, if I could get a motion to conclude considerations on that. Mr. Norris.

Mr. Norris: — Thanks very much, Mr. Vice-Chair. And for the 2012 chapters, I'm happy to propose a motion regarding concluding consideration.

The Deputy Chair: — Thank you very much, Mr. Norris. The motion is for the 2012 report volume 2, chapter 49, to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Now the 2014 report volume 2, chapter 54, if I could get a motion to conclude considerations. Mr. Norris.

Mr. Norris: — Great. Thanks again, Mr. Vice-Chair. Regarding the 2014 volume 2, chapter 54, I'm happy to put forward a motion concluding consideration.

The Deputy Chair: — Thank you very much, Mr. Norris. The motion is for the 2014 report volume 2, chapter 54 to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Thank you. And now we'll move on to part three, which is the 2013 report volume 2. My apologies. We have one more chapter to conclude on. That is the 2013 report volume 1, chapter 25. Just one second, please. Sorry about that. As a rookie Chair, I will own that one.

We will be moving on to part three, which includes two different reports. One is the 2013 report volume 1, chapter 25 and the 2013 report volume 2, chapter 43. We will group those two together. And at this point I'll turn it over to the Provincial Auditor.

Ms. Ferguson: — Thank you, Vice-Chair, officials, and members here. These two chapters are linked in that they both relate to a follow-up of a 2011 audit that we did. It was one outstanding recommendation, and we're very pleased to report in chapter 43 of our 2013 report volume 2 that by July of 2013 the authority had implemented this recommendation. It had established written procedures for maintaining medical equipment at all of its health care facilities. So the recommendation's fully implemented. That concludes our presentation.

The Deputy Chair: — Thank you, Ms. Ferguson. Mr. Hendricks, do you have anything to add?

Mr. Hendricks: — No comments other than thanking the region for complying with the recommendation.

The Deputy Chair: — Thank you. Is there any questions from the committee? Seeing none, if I can get a motion to conclude considerations on the 2013 report volume 2, chapter 25. Mr. Norris.

Mr. Norris: — Great. Thanks very much, Mr. Vice-Chair. I just want to make sure I have this correct. It is for 2013 volume 1, chapter 25?

The Deputy Chair: — That's correct. We've already reviewed this as a committee and we just need to conclude considerations.

Mr. Norris: — Great. So I'm happy to put forward the motion for concluding consideration on this chapter.

The Deputy Chair: — Thank you very much, Mr. Norris. On the 2013 report volume 1, chapter 25, the motion is to conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Now we have the 2013 report volume 2, chapter 43. Again as we've reviewed this, we just need to conclude considerations. If I could get a motion for that? Mr. Norris.

Mr. Norris: — Great. Thanks, Mr. Vice-Chair. For chapter 43 from 2013, happy to put forward the motion of concluding consideration.

The Deputy Chair: — Thank you very much, Mr. Norris. The motion is to conclude considerations on the 2013 report volume 2, chapter 23. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Sorry, my mistake. I'll clarify that for Hansard. The motion is to conclude considerations on the 2013 report volume 2, chapter 43. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Now we will move on to part four of the Saskatoon Regional Health Authority, which is the 2013 report volume 2, chapter 30. At this point I'll turn it over to the Acting Provincial Auditor.

Ms. Ferguson: — Thank you very much. This is actually a new audit dealing with triaging emergency department patients, and I'm going to turn it over to Ms. Sommerfeld to present the findings presented in this chapter.

Ms. Sommerfeld: — Thank you, Mr. Vice-Chair, and thank you, Judy. This is the last chapter in this portion of the agenda. It's chapter 30 of our 2013 report volume 2. This chapter begins on page 219 and describes the results of our audit of the RHA's [regional health authority] processes to triage patients in its three city of Saskatoon hospital emergency departments.

Emergency departments are a critical part of the health care system that affect patient safety and public confidence in the health care system. These departments often handle large volumes of patients each day. They must prioritize patients quickly and appropriately in order to provide immediate care to those patients experiencing life-threatening medical conditions and timely care to other patients. This is called triaging.

Lack of timely and appropriate care could result in complications adversely affecting the health of a patient and possibly resulting in additional financial burdens on the health care system. Saskatoon's triaging of patients in the emergency department setting is impacted by various factors outside the control of emergency departments. These factors are the lack of alternative care, the use of emergency department space for specialist consultants, and acute care availability. We found that some of these factors, while they are understood, are not sufficiently managed to solve the issues impacting the delivery of emergency services. As a result, we've made three recommendations.

First, on page 224 we recommended Saskatoon establish a process to achieve the goal of reducing less urgent and non-urgent patient visits to its emergency departments. We made this recommendation because, although the RHA has set a goal to reduce less urgent and non-urgent patient visits by 25 per cent in 2013-14, it had not yet identified an action plan to achieve this goal.

Saskatoon recognizes that demand on emergency departments becomes challenging when patients with less urgent and non-urgent conditions seek health services from its emergency departments. Also it is aware that individuals with chronic conditions often come to emergency departments because they cannot obtain community support, long-term care, or access to specialists. Some of such patients can be treated more cost-effectively elsewhere if services were more readily available.

Secondly, on page 225 we recommend Saskatoon provide consultant care for less urgent patients outside of its emergency departments. We've made this recommendation because again, although Saskatoon had set a goal to reduce patients seen by consultants in its emergency department by 25 per cent in 2013-14, it had not yet identified any action plans to achieve this goal. Saskatoon's records show that about 17 per cent of all emergency department visits are for consultation with specialists. This impacts the wait time for emergency patients because all visits to emergency must be triaged and registered and specialists are using treatment areas of the emergency department for their consultations.

Thirdly, on page 226 we recommend Saskatoon establish a process to integrate the management of beds for emergency departments, acute care, and long-term care. We make this recommendation because the number of emergency patients waiting for acute care beds in emergency beds means that those emergency beds cannot be used for the assessment and treatment of other emergency patients. We observed that one hospital had more than 40 per cent of its emergency room beds

occupied by patients waiting for an acute care bed. We found that Saskatoon's emergency department system did not interface with its bed management system, and this could impact how quickly and accurately the emergency departments become aware of the availability of acute care beds and move some patients to acute care beds, making room for other emergency patients.

So moving on to the audit itself, the objective of our audit was to assess the effectiveness of Saskatoon's process to triage patients in its three city of Saskatoon hospital emergency departments. We found its processes to treat patients on their arrival in emergency to when they were first seen by an emergency physician . . . We concluded that the RHA did not have effective processes to triage patients in its three city emergency departments, and made five recommendations.

First on page 231, recommendation no. 4, we recommended that the RHA implement a process to direct patients entering its emergency department to the appropriate areas for assessment and reassessment. We made this recommendation because the configuration of the RHA's triage waiting lines are confusing. Triage waiting lines consist of a series of chairs where patients are expected to sit in order of arrival and move down the line when the next patient in the queue is able to be triaged and registered. These lines are not well identified. This increases the risk that patients are missing the triage line, resulting in them waiting in waiting rooms without being triaged, and this may in turn create patient safety risks.

On page 232, recommendation no. 5, we recommended the RHA's staff routinely reassess patients in emergency department waiting rooms to determine if their conditions have not deteriorated. We make this recommendation because best practice standards using the Canadian triage and acuity scale, that is CTAS, and the RHA's own policies both expect patients to be reassessed by a nurse between being triaged and being seen by a physician. We observed that nurses did not leave their triage stations to reassess previously triaged patients in waiting rooms.

Management confirmed that nurses seldom have time to leave the triage station to do this reassessment, and this increases the risk to patient safety.

[11:00]

Our next two recommendations are related. On page 232, no. 6, we recommend the RHA accurately measure and report the total wait time starting from the patient's arrival in its emergency department until the time they see a physician. On page 233 no. 7, we recommend the RHA establish processes to ensure emergency department patients see physicians within established time goals. We made these recommendations because the RHA does not measure and report total wait time as consistent with the CTAS time goal, even though it said it did, and it does not have processes to address long triage wait times.

We found that Saskatoon's measurement of time was incomplete. It only measured how long a patient waits after being triaged to see a physician. It failed to include how long patients wait to be triaged. Saskatoon estimates that patients can wait an average of least 25 minutes before they're being triaged. Figure 2 on page 221 sets out the CTAS time goals. Saskatoon reported that 63 per cent of the time it had met the CTAS standard of patients being seen by a physician within 15 minutes, but we found that it did not. Rather we found that the triage files we reviewed, nearly half of the patients were not seen by a physician within the CTAS time goal because the RHA does not include the time waiting to be triaged.

To more accurately measure the length of time patients wait to see a physician, the RHA must systematically collect data on how long it takes patients to be triaged and put processes into place to address long triage wait times. This would help reduce the risk that patients are not being properly monitored or managed.

On page 223, no. 8, we recommend the authority periodically review the triage process to determine whether emergency department patients are appropriately categorized by the CTAS scales. We found the RHA did not sufficiently take into account the extent to which triage nurses override a system-assigned CTAS level when it decided not to review the accuracy of assessed CTAS levels.

Health authorities use CTAS levels to convey the severity of a patient's condition and to help determine how fast they must be seen by a doctor. Saskatoon's triage nurses, when triaging emergency patients, used a computer program that automatically assigns a CTAS level based on the patient's primary complaint and vital signs. Although nurses cannot manually lower the system-assigned level, they can, using their judgment, override and assign a higher level. Our review of triage files show that triage nurses overrode the system-assigned level for almost one-half of the files.

Periodic review of triage notes and charts where system-assigned CTAS levels are overridden would help the authority understand the reason why triage nurses frequently did not agree with the system-assigned CTAS level and assigned a higher level. This in turn would help it assess the implications on its emergency department services and possible need for further training of triage nurses. That concludes my overview of the chapter. Sorry.

The Deputy Chair: — Thank you very much. I think you were done one way or the other. Thank you very much for that, Ms. Sommerfeld. Mr. Hendricks, if I could get you to address the recommendations. I believe there is eight.

Mr. Hendricks: — Yes. Thank you. First of all I'd like to reintroduce Mark Wyatt, my assistant deputy minister who's joined me at the front. Before we begin addressing the specific recommendations, I feel compelled to speak to the larger provincial initiative around eliminating emergency department waits.

As the auditor has noted, and we do appreciate their work here, this is a very complex problem. If it were just about the emergency room, it might be a lot easier, but it's actually the emergency room is an indicator of flow issues across the system. So as the auditor has noted, it's about having appropriate access for urgent and less urgent care or patients in the community. One area where we would differ slightly from the auditor is in when they do show up that we need to treat

them as efficiently and as effectively as possible. I don't know if that's a difference. And again, you know, on acute care flow, making sure that patients are moving through our acute care system and that long-term care patients are not waiting in our acute care system for a bed.

This forms a body of work that the Ministry of Health and health regions are working very hard on. It's our key system priority for this fiscal year and will be again for next fiscal year and one that will occupy much of our time because, as I said, the benefits of addressing ED [emergency department] waits and those sectors that lie on either side of it will yield great benefits for all patients and residents in our health care system in terms of the quality and access of patient care. So I'd ask Mark to talk about a couple or a few of the specific actions that we are undertaking at the current time.

Mr. Wyatt: — So the response, I would say, to the auditor's recommendations come in a couple of forms. One would be activity that's being led, as Max mentioned, through the provincial initiative. And then there are other more specific issues that are addressed here in terms of triage that I think are very more localized to the region itself. So at the provincial level, we are trying to address I guess in a comprehensive way all of the issues that result in patients waiting, patients requiring that . . . The whole requirement for triage and reassessment is a factor of them waiting.

So in looking at that, the root cause in some cases is found in the emergency department but is more often found in the fact that you have a backlog in the emergency that's a result of a backlog in your in-patient beds resulting in . . . because of a backlog that may be found in community placement or home care even further downstream.

So the response that we're taking as an initiative, rather than trying to focus exclusively on where you see the canary in the coal mine, which is in the emergency department itself, to look upstream at those patients who should most appropriately be treated in a community setting either by a primary care physician or mental health services or another more appropriate and probably patient-focused method of dealing with that patient's concerns. We also have a segment of the initiative that is working within the emergency department, another segment that's looking at patient flow through facilities, and then the fourth would be further downstream in looking at the discharge transfer into community and helping to support patients once they've left hospital care so that they aren't requiring readmission and cycling back in through the doors of the emergency department. So that's the approach we're taking.

Some of the things, just to briefly touch on a few of the initiatives across government, things like the hot-spotting initiative which starts to look at who are some of the frequent users of emergency departments and in-patient services and identifying them and starting to really drill down and understand what are the ways you can better serve those patients. Seniors' house calls would be another example. HomeFirst would be I guess tailoring home care services to patients as they're being discharged from hospital and really focusing on what their specific needs are and helping to support more, helping to facilitate and expedite a discharge by making sure that those home care services are available to patients once they leave the hospital.

So those are just some of the examples. And there are a number of other things at a provincial level that we could speak to just as it pertains I guess directly to some of the specific triage issues.

Do you want me to walk through the high level? I think we would say, across the board, the region is has work in progress and is making progress on the recommendations, on each of the recommendations. There are none that we would say that have been fully addressed and fully resolved, so I think we would describe them all as being in progress.

Around the efficient treatment of patients, the region continues to focus on being efficient in their treatment of patients in the emergency department. The region has developed a rapid assessment unit which is a single assessment room where physicians can assess and treat multiple low-acuity patients.

For care outside of the emergency departments, several initiatives have been undertaken to provide care to patients outside of the emergency department, such as the HomeFirst program pilot project. The police and addictions crisis team is another example. These programs enable an individual to receive medical care without being transported to the emergency department.

Another example of an improvement directly relating to the recommendations is those patients who are coming for a consultation with a specialist who do come in the door through the emergency department. Work has been undertaken so that cardiology patients have been relocated to the heart assessment unit, which results in the ability to see those patients without them becoming emergency department patients. They move directly to the unit area, which also has the benefit of opening up I guess more capacity for the emergency department itself to deal with other emergency patients coming in.

The region has taken steps to improve the emergency department waiting room process by having what's called a pivot nurse, or the captain is another name that is given. That nurse meets and initiates communication with patients on their arrival, or she can do a quick visual inspection as they present to the registration desk. That person is also responsible for reassessing patients in the emergency room where they are waiting to ensure that their condition doesn't deteriorate and to make any reassessment of their CTAS urgency scale as they wait to see a physician. The nurse also documents the patient's length of stay in the emergency department.

One other change that is really important around the processes and that initial delay that you identified as patients come in and wait for triage, the introduction of the pivot nurse but also they've decoupled or separated the registration and triage process. So in the past where the patient would come in and registration and triage would both . . . Both of those processes occurred at the same time. What they found was that if the triage desk wasn't available, you may have a situation where you have patients waiting who could be registered. Both the patient and the registration desk is available but because they were doing it jointly with triage, it was delaying the registration process.

So they've separated those two, so now the result being the patients, when they arrive, may or may not kind of be stopped and questioned by that pivot nurse, depending on I guess their condition as they arrive, but would move immediately to registration. The clock begins ticking once they arrive at registration, and typically they're reporting that the registration occurs about within a minute of arrival.

And finally just on bed management, the region has also implemented strategies to enhance efficiencies in bed management. These include a reduction in lead time for patients requiring a specialty bed on an in-patient unit and the implementation of a bed management system with the expected day of discharge identified on patients within 24 hours of admission. As well, 28 additional beds are being added to City Hospital to allow for convalescents outside of . . . still in the hospital setting but without necessarily requiring a transfer into long-term care. So I'll close there.

The Deputy Chair: — Thank you very much, Mr. Wyatt. Open it up to the committee for questions. Seeing none . . .

Mr. Wotherspoon: — There's quite a few probably.

The Deputy Chair: — Mr. Wotherspoon.

Mr. Wotherspoon: — Sure. These are important areas. And I appreciate that it's a complex system, and so there's a lot of important work that needs to occur. There was a discussion about a promise that had been made around the emergency rooms and I guess eliminating the wait time. I think this came from the Premier and I'm not . . . I could go back and reference what that specific promise and timeline was. Could you just share that maybe with the committee?

Mr. Hendricks: — Yes. The growth plan referenced eliminating wait times in the emergency room. I think that one of the things in, you know, giving that advice to government is recognizing how challenging this problem is and the various pieces that are at work here. And so as a ministry and as a health system, we are working hard to look at what we have to do in order to actually achieve that goal and actually what that goal should be. So I think it's fair to say it might take us a little bit longer than originally proposed to achieve that, but we want to get this right and we want to make sure that we're actually addressing everything across the system that needs to be addressed.

In terms of what we think about no waits, I think the public has reasonable expectations in terms of what they regard as a wait. And I think there's an expectation that they be seen within a reasonable amount of time, that they start to feel that their care is in progress. And so that's what we're looking at.

I think it would be, you know, it would be unrealistic to expect that everybody would immediately start receiving full . . . you know, as soon as they walk in the emergency room. But I believe the public is reasonable in this regard, and it's something that, you know, we have captured the spirit of what we're trying to achieve. And it goes back to our improvement, kind of what we use in terms of setting goals for improvement. We don't strive for half; we strive for zero, right? And so we're working hard on it. I think that the team that Mark has set up and that he oversees is making some good progress. We're quite encouraged by the early work, and we just need to carry through as a system.

[11:15]

Mr. Wotherspoon: — Now the Premier made this promise and set a timeline. And it seems that it's sort of gone, I guess, in a bit of the other direction despite a lot of, I know, hard work from those that are managing a complex system. Has the Premier from your perspective understood that, I guess, what he promised isn't going to be delivered?

Mr. Hendricks: — Well first of all, I would say that the Premier obviously this was something, when he was looking for improvements in the health care system, that the Ministry of Health said this was an area that we would like to work on and here's the time frame. We've been doing a lot of work across the health care system in terms of eliminating surgical wait times, that sort of thing.

And so were we 100 per cent realistic in terms of what the time frame that we thought we could achieve this in, like us? Probably not. And as I said, once we started looking at all the pieces that were involved here and the complexity involved, you know, it caused us to re-evaluate the likely time frame. So you know, we're going to be making a lot of progress on this file over the next year, and we will set reasonable goals for the health care system. And I think it should be reassuring that we're actually, to the citizens of this province, that we're actually tackling this complex issue.

Mr. Wotherspoon: — So just to go back because it was, you know, a fairly bold commitment, promise that was made. When the Premier made that commitment, did he, did Health, the Ministry of Health support that being a realistic goal and have plans in place that would support that timeline?

Mr. Hendricks: — Yes. We felt that it was an achievable goal at that time. But as with surgical care, a goal was set there and, you know, there wasn't 100 per cent achievement of that goal. But if you look at the gains that were made within the four years in access to surgical care, yes, we didn't hit the three months by the end of 2014, but the improvements were, I would say, nothing short of actually remarkable, considering where we were. And we continue to work towards knocking off the tail end of that into March 31st, 2015.

So not unlike that, when you get into a big, large change initiative like reducing surgical wait times or tackling emergency room flow — which, as I said, is a much bigger issue — sometimes you have to re-evaluate and recalibrate your estimates based on that. So occasionally, yes the ministry is very optimistic about what we can achieve and we want to do a lot in a short time frame, but sometimes we have to re-evalute.

Mr. Wotherspoon: — None of the recommendations that have been put forward have been addressed fully at this point in time. I'm just wondering, there wasn't I guess a specific response to each of them as far as timelines towards compliance or to ensure compliance and then very specific actions that'll be taken. Should we go through each of them, or would your officials or yourself be able to provide a bit of that information

on the recommendations?

Mr. Hendricks: — We can go through some specific actions that are under way. I think the point, and Mark highlighted a few of the actions, there's been a lot of improvement work, and a lot of it's been attached to the work that we've been doing about lean and looking at our flows and processes within the emergency room and involving patients in that.

So there has been a lot of improvement work which I can go through for each recommendation if you would like. Our gauge of whether it has been fully implemented is whether it's been implemented in all three hospitals in Saskatoon and whether it's actually being practised consistently and effectively on an ongoing basis. So we don't feel that we've yet achieved that goal. We still have waits in our emergency rooms. And so we would, you know, I think rather than argue that we've implemented, we would acknowledge we've got more work to do in this area.

Mr. Wotherspoon: — What's happening with wait-lists as far as the . . . What are the numbers saying?

Mr. Hendricks: — Surgical wait-lists?

Mr. Wotherspoon: — Or on the emergency room waits, sorry. Wait times.

Mr. Wyatt: — The wait times are measured at a couple of different stages. And so, typically, you would measure the time; the kind of nationally recognized measure, the first measure would be the time waiting for a physician initial assessment. That measure is then broken down by each of the different CTAS urgency groupings. And so for your immediate resuscitation patients, for example, those typically coming in on an ambulance unconscious, having a heart attack, the target for those is immediate response. The typical response time that is logged is probably about 15 minutes, but there's actually no degree of confidence in that number because what happens is the people who are responding to somebody arriving who needs resuscitation is not to log on to their computer; it's to actually treat that patient. And so across the system the response to the resuscitation patient shows an amount of time, but it's an immediate response.

The next category would be emergent. Those are patients who can be any number or a range of conditions that they arrive in, but they are in distress. They need treatment within . . . The goal is 15 minutes. There the region is probably sitting around a 20-minute response time.

When you move to the next three categories — urgent, semi-urgent, and non-urgent — the target times for initial assessment are 30, 60, 120 minutes. And again these times are set by the national Canadian Association for Emergency Physicians. They're sort of the time frames that are often used in the emergency world. The region is sitting around an hour for each of those, just under an hour for the urgent and slightly over an hour for the semi-urgent and non-urgent. So these would be, you know, it's a recognition that when you see patients who are sitting in an emergency room waiting room, they are typically not your level 1's and 2's. Those patients move very quickly into care. The people who are sitting for any amount of time are typically the 3's, 4's, and 5's, waiting to see a physician, waiting to have their diagnostic reports or tests completed, and then moving on to disposition.

There's a couple of other measures around wait times. The other one would be the wait for an in-patient bed, and that's once the patient has seen a physician, moved into the care process, and then they're waiting. If they require an admission, that's the time waiting for the placement to an in-patient bed.

There's other ways where you measure the entire time a patient stays in the emergency department. The one that I've given you around the physician initial assessment is probably the one that's most, it's the one that's most directly related to the audit recommendations but, as we talked about, impacted by those downstream factors that take you into the movement through the system to an in-patient bed and then blockages that you have once you get into the in-patient world.

Mr. Wotherspoon: — So the auditors identified that the Saskatoon Health Authority isn't tracking these wait times in an accurate fashion, isn't reporting it accurately. And she references some of the, I guess, CTAS standards that are in places. Is this something that's been addressed? Has this been resolved so that that reporting is accurate and consistent with sort of national standards?

Mr. Wyatt: — If I understand the auditor's recommendations, there are a couple of areas where they've raised concerns, one of which is when the clock starts. And so in a situation where the patient arrived but was having to wait to be . . . And as I said previously, they were doing registration and triage jointly. Where you have a wait, I think their observation is that the time that you are using to measure the patients' wait to see that physician initial assessment didn't include the initial wait for registration triage.

With the change that they've introduced into the system now with the patient being registered first and then moving on to triage, I think that concern about a period of time that is not calculated into the wait time has been addressed by virtue of the registration happening more immediately and the time that the patient arrives being reflected by their arrival and registration, as opposed to the previous system where there was a more extended delay as you were waiting for both the registration and triage to occur simultaneously.

I think there are some other observations around, I guess, around the way that the measurement was calculated. I'm not sure if there's anything . . . I've addressed one of them. I'm not sure if there's one more specifically that you had in mind.

Mr. Wotherspoon: — I'm interested maybe in just hearing from the auditor on that front to see if . . . So what you're reflecting is that you've changed practice to possibly have implemented this recommendation around the concern of the inaccurate reporting of the wait times. And I'm hearing from you, you've changed the system that may have addressed that concern, but I want to make sure I'm fully understanding what's been . . .

Mr. Hendricks: — Perhaps I can clarify.

Mr. Wotherspoon: — Sure.

Mr. Hendricks: — It was implemented at St. Paul's and it's being replicated right now at RUH [Royal University Hospital] and City Hospital. So that's why we said still in progress. But I think the auditor would agree that the change where you register within basically a minute and the clock starts would address the concern about accurate measurement.

Ms. Ferguson: — That's exactly right. You know, as management has described, our concern was when the clock starts. The clock, in our view, as CTAS indicates, the clock should start when a person walks into the emergency department. The change that they've described, once they push that across to all the hospitals within the region, will meet our recommendation.

It'll be important though, I think, as they think forward and do comparative data so that they're not doing apples/oranges if they're looking at trends, because obviously prior period data won't capture that preliminary information. So you know, we just caution the health authority when they're looking at their trends to make sure it's clear that you may have a bit of an apple/orange comparison as this new process rolls forward in the reporting aspect.

The Deputy Chair: — Thank you, Ms. Ferguson. I just want to take a momentary break and introduce Ms. Chartier, who has joined us. Thank you very much for traveling in from Saskatoon to be able to join us today. Thank you. Mr. Wotherspoon, did you want to continue?

Mr. Wotherspoon: — I've got some other questions, but if there's other members . . .

The Deputy Chair: — Are there any other questions from any other members at this time? Okay. Mr. Wotherspoon, the floor is yours.

Mr. Wotherspoon: — Just on the matter of the one recommendation around reassessment of those that have come into emergency rooms, recommendation no. 5, to ensure that conditions haven't deteriorated. What's the ministry's perspective, I guess, on that recommendation, and what sort of progress has been made towards implementation on that front?

Mr. Wyatt: — This would be the recommendation that has been addressed. And again it's rolling through the different hospitals with the introduction of this pivot nurse or triage captain position. And that does a couple, it addresses a couple of issues, one of which is when a patient presents, if you do . . . I mean in a situation where you do have any kind of a lineup at registration, if for whatever reason there is any delay, the pivot nurse is in a position to identify a patient who is in some distress and more immediately move them.

It may take the form of moving them past the registration triage process entirely, as you would do with a patient arriving in an ambulance, for example, where the registration will often happen once they're in a treatment room, and they don't, you know, sit the ambulance bed in front of the triage or registration desk. So they're in a position to be able to assess patients who are likely, a walk-in patient can still be in a CTAS I or II condition, and so to be able to identify quickly if you have a patient who needs to be moved directly into care.

The other role that that position is addressing is the concern that was identified in the auditor's recommendations about those patients once they've been registered or triaged. If their condition starts to deteriorate, if there's a change of any kind, the concern was that if the triage nurses are busy and can't get up and circulate and really check on the condition of those patients as they're waiting, the pivot nurse position, that becomes their role is to go and do that assessment of patients to make sure that if anybody who presented as a CTAS IV but in the course of an hour, as they're waiting to get in, there is the potential that they need to be re-evaluated, their CTAS score reassessed, and moved more immediately into the care process.

[11:30]

Mr. Wotherspoon: — Thank you for the responses. You've highlighted the complexity of the system and some of the pressures in acute care and long-term care and the needs to address those systems and do so in a way that understands the whole system and how it interacts with itself. Could you speak more directly to the role of primary health in addressing this issue as well, and how does it fit into the mix.

Mr. Hendricks: — Primary care is critical to this. One of the things that we found in some of our preliminary evidence gathering for our ER [emergency room] waits initiative is looking at the number of people that are not connected to a family physician or a primary care team. The number is quite high, so what we want to do is focus on getting families and individuals working with a consistent care provider in the community. But the other issue too in terms of, you know, that community access and primary care is making sure that we have clinics that do provide access beyond regular business hours because oftentimes those less urgent, non-urgent issues occur at 7 or 8 in the evening, and that's when the default becomes the emergency room. So we want to include expanded hours as part of that but certainly having people connected to a primary health care team.

As Mark mentioned, the other issue too is a lot of people that are coming into our emergency rooms are complex mental health care patients and people with other illnesses that we think could be better managed outside of the emergency room. And what this requires is it requires an interagency co-operation. We've started as part of Saskatoon, as Mark noted as well, working with policing to look at alternatives to deal with people rather than just having them bring them into the emergency so that we can provide the appropriate supports for these complex patients. So that's part of our hot-spotting initiative. And the work has begun.

Regina actually is really progressing on this and identified and is working with some of its first patients now. So we're quite optimistic that that will reduce the burden as well by treating people in the appropriate care setting.

Mr. Wotherspoon: — Thanks. Definitely the primary health care teams are critically important. I continue to hear a lot of concerns about the access to primary health care across Saskatchewan and specifically in Regina where I have a lot of

relationships and listen to a lot of families and listen to a lot of our physicians as well. There's big pressures. Could you speak specifically to what the ministry would recognize as the shortage of general practitioners in Regina.

Mr. Hendricks: — Yes. So across Saskatchewan the number of physicians and the number of family physicians has grown significantly, but we're also at the same time facing, particularly in our urban areas, a rapidly growing population. And so, you know, as we've had some or quite a bit of success actually with SIPPA [Saskatchewan international physician practice assessment] in terms of having physicians fill positions in rural Saskatchewan, we started to look at SIPPA and the role it can play in terms of populating some of those positions in our urban centres now.

But the real goal here and the key focus of the recruitment agency will be making those connections with our College of Medicine graduates and making sure that family medicine residents who train in Saskatchewan do stay in Saskatchewan. And I think we're making progress on that front. Do we have work to do? Yes.

But you are correct. There are a number of people that don't have access to a primary health care provider either because it's difficult to find a physician that is accepting patients or because that's not their normal . . . And we have to build that practice of actually having a normal or a regular primary health care provider. Some people just tend to use walk-in clinics or the ER. And so there are a couple of things that we need to do.

But the Regina Qu'Appelle Health Region is doing a lot of work in terms of identifying where they would situate primary health care teams and looking at how we could actually implement and stabilize those teams in Regina. And it is in a lot of our underserviced areas actually, in the central north area of the city, and that sort of thing. And similar work is occurring in Saskatoon. So we do know that this is an issue and it's one that our regions are focused on addressing.

Mr. Wotherspoon: — Do you have a number that you'd recognize as the shortage of family physicians in Regina?

Mr. Hendricks: — We don't have a number on the . . . But having said that, we are in the near future . . . We've been working on a physician resource plan for the province, and that will act, I will say it'll act as a guide. It's not just about doctors. It's about other physician extenders so, you know, your allied health care professionals, your nurses and others or nurse practitioners who can assist a doctor with providing that primary care coverage. We've seen some successes in that regard in Saskatoon, and so I think that we're going to be looking at it in that context. What are the group of providers or the range of providers that we need to provide good primary care to our populations in urban centres and rural centres?

Mr. Wotherspoon: — Would you be able to provide at a later date here the information that you would have that would recognize the shortage as the ministry sees it, the shortage of family physicians in Regina?

Mr. Hendricks: — It will be coming out at some time. And as I said, it won't necessarily be . . . I don't know that I would be describing as a shortage as much as we're trying to address these issues with a combination of providers. You know, it's not just going to be we're short 50 docs, so we've got to go get 50 docs. It might be a combination of providers to address primary care needs.

Mr. Wotherspoon: — Okay. But the information's had by the Ministry of Health, but it can't be provided?

Mr. Hendricks: — It's still in progress. The report is still being developed. It's not complete yet.

Mr. Wotherspoon: — Okay. I hear different estimates from I guess those in health care on that front, and I look forward to that information.

The primary health care teams are really important in the deployment of the allied professionals, the different roles. The nurses are definitely a key piece. I'd heard about the potential of some nursing roles being added to some of the complements here in Regina, and I guess I would like to hear why that hasn't happened.

Mr. Hendricks: — I'm not aware of why that wouldn't have happened. I can check into it. I'm not sure.

Mr. Wotherspoon: — I think there had been some discussion and maybe some level of commitment around supporting some nursing roles into some of the primary health care here in Regina, and it's my understanding that those dollars aren't going to be necessarily provided now at this time for that role.

Mr. Hendricks: — I'm not aware of a decision of that nature. I will point out, you know, oftentimes our focus is on the physician in primary care. Actually our challenge a lot of times is finding a nurse practitioner as well. You know, I think in terms of physicians we've been experiencing a lot of success, but oftentimes identifying those allied health professionals to work as part of that team is equally challenging. So we're looking at various strategies to address that as well. So again I'll check into that. I'm not sure what you're referencing. It would be unlikely, if we had a nurse practitioner that was willing to work in a primary care clinic, that we would be saying no.

The Deputy Chair: — Thank you for that, Mr. Hendricks. I'm wondering if we can contain the questions to the auditor's report. I understand that there's some . . . this has a provincial impact, and I certainly respect that. But if we can keep on the Saskatoon Regional Health Authority and the recommendations, the eight recommendations on there. Ms. Chartier, did you have a question? Sorry. Mr. Wotherspoon.

Mr. Wotherspoon: — The Public Accounts Committee is here to consider the reports of the auditor, and that's always the primary consideration. But the scope and mandate of the committee is much broader than that, and it would be certainly inappropriate to limit and confine discussion or questioning simply to the recommendations as long as the question's related directly to the mandate and scope of the committee.

So these are questions that relate directly to the officials that are before us here today and within the scope of the committee. So

I'd have a couple other follow-ups I'd prefer to move forward with before we have it moved along.

The Deputy Chair: — And I absolutely recognize that there's broader questions that need to be asked. And I don't have an issue, Mr. Wotherspoon, with you asking a few more questions on that. And then we can bring it back to the Saskatoon Health Region and the eight recommendations that are in chapter 30. Thank you.

Mr. Wotherspoon: — Yes. We've touched on quite a few of those as well and looked at some of those timelines, requested some of that information. Those are important, but certainly the primary health piece does impact this as well. And I am hearing, certainly I hear the reality of many not being able to access the family doc. But also chatting with those family docs, they're really in a tight spot here as well, and they have some practical plans I think that could be supported. I think there were some commitments that may have been in place around some nursing roles to complement those, some of those teams. And it may be just for the Ministry of Health to maybe follow up with some of the folks in the region to see if there's some plans that could be supported, would be great.

I also look at some of the succession around family doctors as a big challenge. And if you look at really even the age of those doctors here in Regina, for example, and it's them sharing this with me that, you know, really if they start to make that choice to retire, we're really in a . . . We're taking a very difficult position right now and creating a crisis. So just making sure that we're managing this complex system with all of the attention it deserves and making sure that primary health care has that. And I continue to hear concern that there's many physicians that are choosing not to enter into that family physician type role, and I think there's some different perspectives as to why that might be occurring. But I think that's an important area to be studied in an urgent way by government to make sure that those conditions are welcoming and encouraging, to make sure that we're addressing those gaps and making sure we have good, strong primary health care teams in place in Regina and all other centres across Saskatchewan well into the future. So I'll pass the question over.

The Deputy Chair: — Thank you, Mr. Wotherspoon. Ms. Chartier.

Ms. Chartier: — Thank you very much, Mr. Chair. I have a couple of questions around, well the first round hot-spotting, as you've addressed, that there are people who have significant and chronic mental health conditions who show up in emergency rooms. And last year's budget had the hot-spotting initiative. You talked, just touched on Regina. Conversations that I have had in Saskatoon a few months ago, I'd understood that there was some significant challenge gathering data, privacy, trying to figure how to roll out hot-spotting. And so I'm wondering how you've met some of those challenges and, both in Saskatoon and Regina, what is hot-spotting looking . . . What does it look like?

Mr. Wyatt: — The focus in Regina and Saskatoon both are looking at high repeat users of the acute care services. In Saskatoon the initial focus look was going to look more directly at patients who have a mental health dimension to their chronic condition or to their health needs. So they have been using the data and trying to identify those patients who have a . . . where their high utilization of acute care services relates to a mental health condition. They're going to be continuing, and I think they've narrowed that down and started to be able to reach the individual patient level. They have not yet begun to make contact with those patients and begin that process of talking to them about how to manage and reduce . . . manage their care more appropriately, thereby reducing the demand on, you know, emergency visits, the acute care system.

In Regina they're also again looking at high utilization as kind of the data review that's undertaken. In that case, they haven't taken an exclusive mental health focus but have looked at a range of patient diagnoses, and in many cases it does involve either a mental health or a combination of physical and mental health issues. So again in Regina, also a high, a high proportion of that population does have mental health issues, but they haven't started exclusively there.

[11:45]

In Saskatoon I think they are going back to look beyond the initial focus which was around, specifically around mental health, patients with mental health requirements. And in addition to those patients, they're starting to look more broadly at the patient population. In Regina, as Max had mentioned, they have begun to approach the first patients and are starting now to actually work with those patients on developing their care plans and finding out what their needs would be.

Ms. Chartier: — Thank you for that. How have you managed the privacy concerns? Because obviously you've said you've identified, looked at the data and identified the individuals and seem to have resolved that in Regina. But how have you addressed the privacy concerns of reaching out to people who tend to use emergency rooms repeatedly?

Mr. Hendricks: — Well as you know, in health care, privacy is always a key consideration. Where we've I think experienced more challenges with privacy is it relates to the Hub and the interagency co-operation and the sharing of information amongst agencies. And we've made that a key priority in trying to address those issues where we feel that — you know, within and working with the Privacy Commissioner — where we feel the needs of the patient warrant some sort of intervention. And so we're glad that the new Privacy Commissioner is open to discussion about this, but it's still something that we take seriously.

And in the case of health care, when we have identified high users of the system, I think it's within our prerogative actually to actually intervene and say, you know, there is a better way that we can be providing services to you so that you aren't coming to our emergency room. And in fact the first client in Regina was very appreciative to be approached about this and have alternatives that they weren't aware of, so I think that we're going to experience a lot of that.

You know, right now there's the hot-spotting that we're doing in the health care system, looking at the high users of our emergency rooms, but eventually that's going to be integrated with work that will be done in social services and policing and

education to identify people who are showing those signs across various human service agencies. And hopefully I think it will enable us to prevent avoidable events, some of which result in very unfortunate outcomes. We are always careful about privacy, but there are certain times when you do have to break the glass. Right?

Ms. Chartier: — I'm wondering about in Saskatoon. You've talked about it's starting to roll out in Regina. So it's almost a year since the last budget, and this was a pretty significant health initiative of the last budget, and I understand it takes time and legwork to get things going. But in Saskatoon, can you tell the committee what that's going to look like in terms of hot-spotting and when you expect it to actually move from identification of users to intervention of some sort?

Mr. Hendricks: — We believe that Saskatoon is probably a couple of months away from identifying their first patients. As Mark said, they've taken a slightly different approach, focusing more directly on mental health patients. You know, hot-spotting sounds easy. You know, you just go into the database and you identify the high users and stuff. But actually identifying high users of the health care system, in particular when you're looking at a specific illness and what you might do for that person once you have them, is a more complex issue.

And when you mentioned privacy, a lot of the sensitivity is around you don't want to identify the wrong person or approach a person who doesn't want to be approached or doesn't have this type of severity in illness. We want to make sure we get this right because, you know, we're dealing with complex conditions, and we want to make sure that when we are approaching people, we do have the resources to treat them, the alternative resources, and that in fact we are identifying the right people.

Ms. Chartier: — I think that that's my question. I don't think that it's easy, and I know it's incredibly complex and takes time to do that legwork. But I'm wondering what . . . Again it was announced a year ago and a pretty significant initiative, health initiative in this last budget. And I'm wondering what you anticipate it will look like in Saskatoon. Do you know that yet?

Mr. Wyatt: — Typically the model would involve having a case manager. And just in terms of I guess the rollout and the timing required for the rollout plan, you would have a dedicated case manager who would directly be the initial point of contact and provide the continuity of contact in the case management. Then once the either physical or mental health needs are identified, then that person becomes the coordinator who is then working with identified care providers, be they physicians, be they social workers.

A lot of the needs for these patients do start to speak to the question of why they don't have a regular family physician, why they may be reluctant to reach out to the health care system and end up having their either chronic condition or mental health issue reach a crisis point before. And so in other jurisdictions where they have introduced hot-spotting, that care coordinator role is often not only dealing with health care issues, but you're also dealing with at times it may be an Aboriginal person who has experiences or a perception of the health care system that is deterring them from reaching out and receiving the kind of care that they need. And sometimes you need to work with them to be able to connect them with primary health care services or other supports in the community, so that relationship is a combination of, you know, starting to address what are the right combination of providers who can work with that patient to meet their health care issues. But as I said, there are oftentimes social work issues and other home-based issues that become part of the barrier to that patient getting the care they need.

Ms. Chartier: — What needs to happen in Saskatoon? You've said probably another couple of months. What needs to happen in Saskatoon before it can start to roll out?

Mr. Wyatt: — I think it's just reaching the final stages of identifying the cohort of patients that you will be working with and then making sure that they have the staff and those case managers in place who then take that next step of actually initiating the contact with the patients. So I think it's just the completion of the path that they're on around bringing together the combination of the right patients with the right group of providers.

Ms. Chartier: — Thank you for that. Obviously one of the challenges when you're connecting people or intervening when you've got people showing up repeatedly at the emergency room is having those services available. And I know one of the issues that we're lacking here in Saskatchewan is supported housing for those who have mental health challenges. So is there, in all this conversation about hot-spotting and in light of our mental health review, is there the discussion about what we need to build this, not build physically necessarily but build the supports and capacity in the system before we can do this well?

Mr. Hendricks: — Yes. Very good point. And you know, I think that that is one of the challenges with this initiative is that it's good to identify them, but you have to have the appropriate supports. And one of them that has been identified and was identified by the commissioner was the need for community supports and housing for complex patients like this so that we have a place to actually provide support for these. Again that's something that's currently and actively under discussion right now as a response to the commissioner's report.

It's interesting. Yesterday I met with the head of the Saskatchewan Housing Corporation and the deputy of Social Services. And you know, a lot of times there is housing available in Saskatoon, that sort of thing, and it's just that it's attaching people to housing with these issues and providing the right supports. So there might be some innovative ways — and in Regina too, there's housing available — innovative ways of making that actually happen. And that's part of the challenge with this work.

And I can guarantee you, Ms. Chartier, you know, if you think it's taken a while and are asking these questions, government MLAs [Member of the Legislative Assembly] are asking me the same questions. They want to see this up and going.

Ms. Chartier: — Just sort of from a pragmatic or practical perspective, I'm curious what it looks like. So I show up in the emergency room for the tenth time in a month. And you've talked about it starting to roll out here in Regina and talked

about case managers. So Danielle shows up at the ER, and you've identified me as a repeat user. How does that intervention look?

Mr. Wyatt: — It may be based on you attending to the emergency. It may quite well be that that is initiated without you actually visiting.

So they would start with . . . And again following a model that's being developed in the United States in Camden, New Jersey and a number of other sites, what you would typically start with in piloting, in sort of rolling out a hot-spotting initiative is to start with a group of 30, 50. You don't want to start with your top 20 per cent or something like that. So they will look at a cut-off either based on utilization of emergency visits or acute care in-patient or a combination of those, and then once they've identified where their cut-off is, looking for a manageable number to start out. I think the number 30. I could be corrected, but the number 30 is sort of the vicinity that we're talking about for the rollout in Regina and Saskatoon.

And then you may be identified. And I think, I believe it's the case that with the first patient in Regina, it wasn't that they showed up in the emergency and they said, okay, you've crossed the threshold. We're now going to enrol you in this program. I think it was somebody who they identified, and it comes back to that data analysis and being able to cross-reference a patient with their usage of the system and then be able to draw out who are the patients who are high-frequency users of the system.

But also the other lens you need to apply is, are these patients where there is something that can be addressed and prevented through this kind of a program? To give you an example, you have many high users, and they would be considered both high, frequent users, high-cost users, but they're in a palliative stage of their care. So you know, I think the assessment is that that's not the profile of the patient that you really want to be focusing on. Those would be patients who need the care that they're seeking. They may be high-cost patients, but this isn't a case where you would identify them in a hot-spotting initiative. And so you need to apply some of those filters as you start to look at by volume, by the number of in-patient stay days. What is the patient profile where we can actually intervene with this kind of initiative and make a difference?

Ms. Chartier: — I've got a couple of more questions, but just one more on this particular issue then. So you said 30 in Saskatoon and Regina or 30 approximately — and I won't hold you to 30 unequivocally, not 31 or 28 or anything like that — but approximately 30 in each health region or total?

Mr. Wyatt: — I believe, I understand it will be 30 in each of the two regions. And then I mean some patients may stay on as part of I guess the hot-spotting program, if you want to call it that, for a longer time. Some may move more quickly through and have their care needs managed and have a process in place where they're comfortable in seeking care in the community. And so there will be some rotation in and out of that group of 30.

Ms. Chartier: — Thank you. Just one sort of last set of questions is actually around the surgical initiative and how it has connected to emergency rooms and increased . . . or lack of capacity in emergency rooms. One of the things that I've been told in Saskatoon is with the start of the surgical initiative — and now I guess the completion, but it carries on — that there used to be a slowdown for surgeries over Christmas, in the summer, those periods of time, and that slowdown doesn't happen anymore around surgeries. And that, I've been told, is one of the things that has created the backlog. And I'm not saying we shouldn't be doing surgeries, but was that taken into consideration when embarking upon this surgical initiative?

[12:00]

Mr. Wyatt: — So I guess just to the first part, there is still some degree of slowdown during the summer and Christmas break. You know, Christmas fell on a Thursday this year. The operating rooms aren't working on a Thursday other than for emergency cases. During the summer period, staff do have holidays granted. And so there is still some reduction in the number of surgeries being performed, as I understand it, in Regina and Saskatoon.

That said, the slowdown that used to occur where it was a large-scale slowdown, the idea was that, you know, you grant all of the nurses and the anesthesiologists, surgeons, time off at the same time and it became more of a shutdown. Now what they're doing . . . And that was the idea but it never really worked because you can't get those groups to all coordinate it. Life's not like that where everyone's holiday plans all happen to magically line up in the month of July or something.

So you ended up with a lot of downtime with either frustrated surgeons who were ready to go but the operating rooms weren't working, or if the surgeons weren't available and it happened to be August, now you've got operating room nurses who are scheduled to work but the surgeons or the anesthesiologists aren't there. So now it's more of a scaling down, but it doesn't look like a full slowdown which is I think what had been done in past years.

In terms of the impact, so how that impacts on medical patients coming in, I guess I'm not aware that there is a correlation during the summer months between the slowdown and a capacity problem. Summer doesn't tend to be one of the times where you expect to see the high patient loads coming in as we see during flu season, and so I'm not aware of that being an issue during summer. Certainly in December, January, the time frame we're in right now, we do. When you do have higher medical patient numbers coming into emerg and presenting in the hospital, there are times when they do have to cancel or reduce the number of surgeries in order to accommodate a higher number of medical patients.

We recognized from the outset that there is a lot of shifting that occurs between medical and surgical bed usage. There are times when some, you know, when either one might not be at full capacity and there is some spillover. But with the surgical initiative, we did acknowledge that we needed, and I think it was true then and still true today, that there needs to be better management of your in-patient flow and that things like rounding of patients, the development of expected date of discharge plans, was all going to be a critical part on the medical side in order to avoid that situation where your medical

patients are spilling over in large numbers into surgical beds.

Ms. Chartier: — Thank you for that.

Mr. Hendricks: — If I could just add one thing, just that the concept of the slowdown is an interesting one. Oftentimes, as Mark mentioned, we slow down at Christmas; we slow down during the summer, that sort of thing. At Christmas . . . There's a good article by André Picard about this. It's interesting. Just because our hospitals are slowing down, our ERs are slowing down, or we're slowing down staffing to accommodate holidays doesn't mean that public demand slows down. And so we need to actually have a look at that because in fact during your peak influenza period those are the times when you need probably to have your system at its optimal performance. So I think it's something that we need to look at and in its way of preventing overtime, that sort of thing, by trying to encourage regular staffing. But it will require breaking some old habits around everybody going on vacation at certain times.

Ms. Chartier: — Just one more question. Sorry, you just reminded me of something. So obviously in this last challenge here in the last few weeks here that we've seen and heard in the media, and we have in the auditor's report here as well, and in the last few weeks we've talked about people taking holidays. So when people take holidays, are people being replaced when they're . . .

Mr. Hendricks: — Yes.

Ms. Chartier: — So how do people taking holidays impact wait times then if they're being replaced?

Mr. Kavia: — So I can speak to that. I'm Nelish Kavia. I'm the VP of finance, corporate services. This year actually was . . . When we talk about slowdowns during . . . It's usually Christmas time, February break, and the summer. And the driver itself is partly what we talked about in terms of staff needing to take the vacation that they take, but in some cases the driver is patients on the surgical side. So particularly times when you have Christmas on a weekday, what we found historically is that patients elect not to take the opportunity to have surgery during that week. And so when we are looking at granting vacation and trying to really level load our staffing to the demand that we would see from a patient perspective, what we've used is historical patient volume data to say that, you know, historically, last year, for example, we saw this much of a reduction in our patient load during this period, and that's been our guide. The trouble with that obviously is sometimes you get surges that are completely unexpected, and this December actually was a bit of an anomaly. We actually saw more of an increase in patients than we had expected.

Ms. Chartier: — Okay. So just to clarify then. In some of the media reports that I had read, it said people were on holidays or that was one of the reasons. So I'm still not quite sure how that impacts service then if people who are on holidays are being replaced.

Mr. Kavia: — When we have vacation . . . At any point in time people take vacation all through the year generally, right? So if it's a front-line position and the individual is on vacation, we have vacation coverage for that position. What we had experienced over the Christmas period this year was coupled by some increased demand that we had not anticipated, coupled with we had a lot of our own staff that actually were off because of influenza and some of the same issues that our public was facing. So that was really the issue that we were facing.

Ms. Chartier: — So again to that question of whether people have vacation or are off sick, some of the challenges we've heard is that we've heard about short-staffing, and you've talked about people being sick. I just am wanting to make sure. And again it was quoted in the media that people being off or away was part of the challenge. I'm just trying to clarify that in fact the complement that's usually in each respective facility was there.

Mr. Kavia: — Yes, our staffing over this Christmas break would have been similar to what we had staffed in the past and, as I mentioned earlier, we used our patient load as a guide as well. So the only difference we would have had this year or last year during the Christmas break, we had some areas that didn't have a lot of patients and so we had some support areas that were staffed that really didn't need to be staffed. So it was really helping people to have a guide as to, if you're granting vacation this might be the right time.

I think your question is, did we actually grant more vacation during that period than we should have? And I don't think that was the case. We had a lot of staff that were away on just having experienced sickness themselves that was unanticipated. And sometimes the protocol is to fill those shifts and you do certainly experience times where you can't fill the shift just because there is nobody available to fill it.

Ms. Chartier: — I think that that gets more to my question. Not so much should you grant more holidays, but what is the protocol? The protocol is to fill shifts. And are they being filled? So I think what I've read in the media, there were many reasons cited for the pressures on the emergency rooms, including a surge in patients, but another one of the reasons was holidays or staff being away. And to my simple mind, well if . . . Are you not replacing staff that are away, whether it's for illness or holidays? That's what I was asking more specifically, not that you were granting more vacation. But what I've read in the media said one thing very specifically that there were many reasons for the challenges and one of them involved staff not being there. So my question is, why were staff not there, and were those positions not being filled? And I think you've answered that.

The Deputy Chair: — Thank you, Ms. Chartier. Any further questions from the committee? Seeing none, I believe we have eight recommendations before us on the 2013 report volume 2, chapter 30. If I could get somebody to make a motion. Mr. Norris.

Mr. Norris: — Great. Thanks very much, Mr. Vice-Chair. I appreciate the deliberations that have been undertaken, and I'll propose a motion that we concur with the recommendation and note progress towards compliance.

The Deputy Chair: — Is that for all eight, Mr. Norris?

Mr. Norris: — That is inclusive.

The Deputy Chair: — Thank you very much. The motion on the floor is for 2013 volume 2, chapter 30, recommendations 1 through 8. The motion is to concur with the recommendation and note progress towards compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Agreed. Carried. And if we could have a brief recess for five minutes. I think if we have the Sun Country Health Region here, we'll have a brief recess and then we will continue with the one chapter that is remaining for Sun Country Health Region after that. So we will recess for 10 minutes. Thank you.

[The committee recessed for a period of time.]

The Deputy Chair: — Thank you everybody for the brief recess. We have Sun Country Health Region here, and we have discussion of the 2013 report volume 2, chapter 31. At this point I will turn it over to the auditor to talk about that specific chapter.

Sun Country Regional Health Authority

Ms. Ferguson: — Thank you very much to committee members and officials this morning. Ms. Kim Lowe is in the chair here, that instead of behind, because she was responsible for the audit that's in front of us here in addition to her responsibilities as liaison with the committee.

As our practice, I actually would like to pause and thank actually the management and staff of Sun Country for the co-operation extended to our office during the course of this audit.

So the chapter before you is an audit that focuses on managing medication at the Sun Country Regional Health Authority. It includes five new recommendations for the committee's consideration, so I'm going to turn it over to Kim to present the results that are contained in this report.

Ms. Lowe: — Thanks. Chapter 31 begins on page 237 of our 2013 report volume 2. Under *The Regional Health Services Act*, regional health authorities are responsible for the operations of hospitals and the services provided in those hospitals.

Hospitals use medications for pain management and the treatment of a wide range of illnesses. Medications play an important role in patient care and operations of hospitals. Some medications are highly addictive and potentially dangerous. Effective management of medication means patients receive correct medication as prescribed, proper amounts of the correct medication, and at the appropriate time. Detection of medication errors is an important part of managing medication, as medication errors can have serious consequences.

We examined the effectiveness of Sun Country Regional Health Authority's processes to manage and administer medication in its district hospitals for a 12-month period ending August 31st, 2013. Our audit did not include individual decisions associated with prescribing medications to patients in hospitals.

We concluded that the authority's processes to manage and administer medication in its district hospitals were effective except for the matters covered in our recommendations. We made five recommendations.

First, on page 241, we recommend that the authority monitor that staff consistently follow its policy of obtaining proper authorization and documenting the pharmacist consulted before entering the pharmacy after regular hours. The authority's policy requires staff to contact senior pharmacy staff to obtain permission to enter the pharmacy to obtain medication. Staff must complete a form indicating the date, time, pharmacist consulted, drug required, dosage, patient's name and location, and quantity taken.

Alternatively staff may contact the community pharmacy to obtain the drug they require. We found that staff did not always follow this policy. They did not always properly complete the required form and, contrary to the established policy, one hospital did not require staff to gain permission from senior pharmacy staff to enter the pharmacy after hours. Not following policy increases the risk that medications are not properly tracked and could be misappropriated.

Second, on page 242, we recommend that the authority train its staff to follow its policy to dispose of wasted medication properly and monitor compliance with the policy. While preparing medication to administer, some medication may be wasted. Such wasted medication must be treated as biomedical waste and disposed of in a biohazard container as the authority's policy requires. During our audit, staff indicated that wasted medication was disposed of by flushing down the toilet or sinks, put in the garbage, or put in a biohazard container. Not following policy over proper disposal of wasted medication increases the risk of harm to people and the environment.

Third, on page 243, we recommend that the authority requires all of its hospitals to use the approved form generated from the province-wide pharmaceutical system to create accurate patient medication histories. We made this recommendation because at one district hospital, staff did not use the approved form which is created by printing information from its pharmaceutical computer system. Rather staff at this hospital manually created a listing of medications for new patients by rewriting information from its pharmaceutical computer system. Rewriting the medication increases the risk that information may be copied wrong or a medication could be missed resulting in medication errors.

Fourth, on page 244, we recommend that the authority consistently complete patient medication profiles by documenting patients' weights. As part of gathering the best possible medication history, nursing staff are responsible for recording the patients' actual weight or an estimate thereof. We found staff did not always record patients' weight. A patient's weight plays an important role in determining the dose of medication for the patient.

Fifth, on page 246, we recommend that senior management of the authority analyze the medication errors and the contributing factors and use that analysis to develop action plans to address the reasons for serious and reoccurring errors. As noted in figure 2 on page 246, management tracks medication errors quarterly and provides this report to the board. However we

found that management did not give the board reasons of quarter-to-quarter fluctuations in the medication errors, breakdown of those errors, contributing factors, risks, or areas requiring actions. Doing so would be useful to help outline emerging risk and actions to reduce medication errors. That concludes my overview.

The Deputy Chair: — That you very much, Ms. Lowe. If we could get the ministry to respond to this, Mr. Hendricks.

Mr. Hendricks: — Sure. Thank you again to the auditor for their observations regarding medication management in the Sun Country Health Region. With respect to the auditor's first recommendation, outstanding recommendation, that "We recommend that Sun Country Regional Health Authority monitor that staff consistently follows its policy of obtaining proper authorization and documenting the pharmacist was consulted before entering the pharmacy after regular hours," the two district hospitals in Sun Country have implemented this. Weyburn General Hospital and St. Joseph's Hospital now complete action logs that record the individual entering the pharmacy after hours, the date, the time, and the purpose, as well as the pharmacist that was consulted. So that has been implemented now and, I would think, would be subject to a future verification by the Provincial Auditor.

In terms of the other ones, "We recommend that the Sun Country Health Authority train its staff to follow its policy to dispose of wasted medication properly and monitor compliance with the policy," we are providing training and orientation to staff in the Sun Country region on proper disposal of medication so that they are not ending up in toilets or waste containers. We agree with the auditor's recommendation here, and that is in progress.

With respect to the recommendation that the Sun Country Regional Health Authority require all of its hospitals to use the approved form generated by the province-wide pharmaceutical system to create accurate patient histories, Sun Country is currently in the process of transitioning to the province-wide pharmaceutical system form to have accurate patient medication history. So that work is in progress as well.

With respect to what is now an implemented recommendation, that Sun Country Health Region consistently complete patient medication profiles by documenting patient weights, that has been implemented now.

And then the recommendation that senior management of Sun Country Regional Health Authority analyze medication errors and contributing factors and use that analysis to develop action plans to address the reasons for serious and recurring errors, the regional director of pharmacy and the regional director of quality and patient safety along with other site leaders develop action plans to address serious and recurring medication errors. And that has been implemented as well.

In terms of the work we're doing provincially on mistake proofing and specifically around medication errors, we're seeing a lot of significant improvements in this area in terms of both medication reconciliation and looking at kind of those error-prone situations that do result in medication errors and I would say, of our work across the province, that it is actually where we're making significant progress. Still work to do, but it's in terms of improvement work that we can do. This is low-hanging fruit, so to speak.

[12:30]

The Deputy Chair: — Thank you, Mr. Hendricks. I will open it up to the committee for questions. Ms. Chartier.

Ms. Chartier: — I think you've addressed part of one of my questions, Mr. Hendricks. So obviously you have one health region where issues are identified and so my question was around, so if they're in one health region, they're potentially in other health regions. So how do you work with the remaining health regions to make sure that these outstanding recommendations are followed as well or that people are doing things the way they need to be doing? So they're identified in one health region but possibly . . . So you've talked about safe proofing. And perhaps I missed some of this discussion earlier, but would you tell me a little bit about that?

Mr. Hendricks: — Sure. The auditor's last report raised issues about medication management in the Heartland Health Region as well, and you know, it is an issue that we do have across the health care system. And as part of accreditation, health regions and hospitals, long-term care homes are supposed to do medication reconciliation with patients on admission, on discharge. But that's not the only source of error. Oftentimes you have situations where, you know . . . We're looking at improvement methods like different packaging to reduce the likelihood of an error, having pharmacists . . . In larger hospitals one of the issues is having satellite pharmacies closer to the patient and having the pharmacist closer to the patient, not interrupting the pharmacists while they're actually putting together the medication trays. There are a number of ways that errors can occur. Mislabelling — this is an area where Sun Country has done work. You have to make sure that all of your medications are correctly labelled and medications that look and have similar names are apart from each other so the chance that somebody could pick up the wrong medication in error are reduced.

And so across regions we are doing this. And if you look at the critical incidents that I receive and that are reported publicly, medication errors are still a significant issue. One of the things that we're talking about is whenever we do have a critical incident, we look at the underlying, the root cause, and we put that data out there to the regions to say, you should look at what changes have been made or improvements have been made in this region and implement those in your region. What we want to do is we feel that regions actually need more help in understanding some of the changes that have been made, so we're going to be more proactive in spreading what we're learning through our mistake proofing and medication management as well as other areas to make sure that we have consistent processes across regions.

Ms. Chartier: — So when some issues are raised in one health region, it is an opportunity to improve them across the board?

Mr. Hendricks: — Yes. I would just say that as part of what we're doing in terms of having daily visual management where we're putting actually up on boards, almost every unit —

medicine unit, long-term care home — tracks medication errors. So it's visible to not only to the people working in the facility, but to their families and patients or residents.

And you know, actually in the fall I was up in La Ronge at their long-term care home, and it was up there. And they spoke about just even having that visible has increased awareness, and they've been successful in driving it down to zero and holding it. So we're seeing that more and more, it's just being aware that these are occurring and looking at the root cause and taking the corrective action. The first thing in recognizing that you have a problem is actually knowing it and measuring it.

Ms. Chartier: — Thank you for that. I think I'm good.

The Deputy Chair: — Thank you, Ms. Chartier. Any other questions from the committee? Seeing none, we have five recommendations for the 2013 report volume 2, chapter 31, if I could get a motion. Mr. Norris.

Mr. Norris: — Great. Mr. Vice-Chair, thanks very much. Again what I'd do is I propose that of the five, we'll divide them into two categories. And so the motion for no. 1, no. 4, and no. 5 would be concur with the recommendation and note compliance.

The Deputy Chair: — Thank you, Mr. Norris. The motion is for the 2013 report volume 2, chapter 31, recommendation 1, 4, and 5, concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Mr. Norris.

Mr. Norris: — Again, thanks very much. Then what I would do is add again for the 2013 volume 2, chapter 31, nos. 2 and 3, that the motion would read, concur with the recommendation and note progress towards compliance.

The Deputy Chair: — Thank you, Mr. Norris. For the 2013 report volume 2, chapter 31, recommendation no. 2 and 3, the motion is to concur with the recommendation and note progress towards compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Carried. Thank you very much for that. Just a couple of housekeeping things here. First of all, I want to thank the auditor's staff — auditor and staff — for all of the hard work they're doing with the health regions, specifically the ones that we talked about today and the ones throughout the province, and making sure that our health system is the most effective that it can possibly be for the patients of Saskatchewan.

I thank the officials. Mr. Hendricks, thank you very much for you and your officials, certainly for being flexible today and working through things. And also I want to thank the people from Hansard to make sure that . . . They worked through the lunch hour to make sure that we could get done a little bit early today.

And I also want to thank Kathy and her staff and the committee as well. I very much appreciate it. We've had two busy days. I think we've got a lot done as far as Public Accounts. We seem to be catching up and getting back on track with things.

I also want to thank Ms. Chartier for allowing me to sit in the Chair today. I very much appreciate that. It was a little bit of a learning curve for me but certainly appreciate that.

And with that, if I could get a motion for adjournment. Mr. Weekes.

Mr. Weekes: — I so move.

The Deputy Chair: — Mr. Weekes has moved a motion for adjournment. Is that agreed?

Some Hon. Members: — Agreed.

The Deputy Chair: — Thank you very much. We stand adjourned until February 12th, 2015 at 9 o'clock in the morning. Thanks again, everybody. Drive safe.

[The committee adjourned at 12:37.]