STANDING COMMITTEE ON PUBLIC ACCOUNTS

Hansard Verbatim Report

No. 37 – September 17, 2015

Legislative Assembly of Saskatchewan

Twenty-Seventh Legislature

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

Published under the authority of The Hon. Dan D'Autremont, Speaker

[The committee met at 09:31.]

The Chair: — Good morning, everyone, and welcome to Public Accounts. Good morning to all our members here. We have a full house and no substitutions today. We have Mr. Wotherspoon, Mr. Marchuk, Mr. Hart, Mr. Michelson, Mr. Weekes, Mr. Norris, and Mr. Doke. Good to see you guys all. I guess we haven't been back as a group since June, I think, so good to see you this morning. And I'm Danielle Chartier. I'm the Chair of Public Accounts. Thank you to the auditor for reminding me of that.

I have a few documents to table before we move on here. I have a PAC 49/27, Ministry of Education reporting on public losses for boards of education for the period from September 1st, 2013 to August 31st, 2014, dated July 3rd, 2015. This came to committee members on July 7th, 2015.

I'd like to table PAC 50/27, Ministry of Finance reporting of public losses for the period from April 1st, 2015 to June 30th, 2015, dated July 30th, 2015. And committee members received that on July 30th, 2015. I'd like to table the PAC 51/27, Ministry of Health reporting of public losses for the period from April 1st, 2015 to June 30th, 2015, dated July 30th, 2015. This came to committee members on August 4th, 2015.

The three following documents: PAC 52/27, the Provincial Auditor of Saskatchewan first quarter financial forecast for the three months ending June 30th, 2015, committee members received that on August 17th, 2015; there's PAC 53/27, the Provincial Auditor of Saskatchewan financial management policies dated July 2015, and that came to committee members on August 17th, 2015; and lastly the PAC 54/27, the Provincial Auditor of Saskatchewan human resource management policies dated July 2015, and that came to committee members on August 17th, 2015.

Do the committee members have any questions, particularly for the Provincial Auditor, in regard to the documents just tabled? Seeing none, we shall move on. I'd like to advise the committee that pursuant to rule 142(2), the following documents were deemed referred to the committee: the Provincial Auditor of Saskatchewan *Annual Report of Operations for the Year Ended March 31st, 2015* on June 25th, 2015, and *Public Accounts 2014-15 Volume 1 — Summary Financial Statements*, on June 26th, 2015.

So with that I also would like to make a few other introductions aside from committee members. Here today with us we have Chris Bayda with the Provincial Comptroller's office. He's the executive director. And Ms. Lori Taylor. Thank you for being in attendance as you always are. I'd like to introduce our Provincial Auditor, Ms. Judy Ferguson, and she'll take the lead on introducing her officials.

Saskatchewan Research Council

The Chair: — Our first agenda item today will be looking at the Saskatchewan Research Council 2014 Provincial Auditor report volume 2. And we have here with us today Laurier Schramm, the president and chief executive officer for the Saskatchewan Research Council, and Ryan Hill, the vice-president, finance. So I will pass it off to the Provincial Auditor who will make some remarks and then I will pass it off to you folks at the Saskatchewan Research Council. Ms. Ferguson.

Ms. Ferguson: — Thank you. Madam Chair, Deputy Chair, members, and officials here, this morning I've got with me, right beside me is Mr. Victor Schwab. Victor is a principal and is responsible for the audit of Research Council. And behind him is Ms. Regan Sommerfeld. Regan is recently promoted to a deputy of the office and she's responsible for our environment and infrastructure team of which SRC [Saskatchewan Research Council] is a part of that team. And beside her is Ms. Kim Lowe, and Kim is our committee liaison.

As noted by the Chair, this morning we're talking about chapter 24 of our 2014 report volume 1 and you'll find that it contains two new recommendations for the committee's consideration. Before we start our presentation I just do want to take a moment and thank the officials, the president and the VP [vice-president] of finance, and your staff for the assistance and co-operation that we received in the course of the audit. We certainly do appreciate that. So without further ado, I'm going to turn it over to Mr. Schwab to present the chapter.

Mr. Schwab: — Thank you, Ms. Ferguson. Chapter 24, beginning on page 143, reports the results of our annual integrated 2013-14 audit of SRC. We report that SRC had effective rules and procedures and complied with related authorities with two exceptions. We make two new recommendations for the committee's consideration. On page 144 we recommend SRC obtain Lieutenant Governor in Council approval as required by law for the remuneration it pays to its board members. *The Research Council Act* requires the Lieutenant Governor in Council to determine remuneration rates of the board. This means the Act expects cabinet to approve the rates and make those rates public.

In November 2009 treasury board approved an increase in the board remuneration rates for members of SRC's board. By March 2014 SRC did not obtain the approval of Lieutenant Governor in Council of this increase in rates. As such, the remuneration rates of the board are not properly approved or made public.

Also on page 144 we recommend SRC report losses resulting from fraud or potential illegal acts as required by the financial administration manual. The financial administration manual requires SRC to report losses resulting from fraud or potential illegal acts. In 2013-14 SRC incurred a loss because a third party failed to remit to SRC proceeds from its sale of SRC's assets. SRC had consigned these assets to a third party for sale. SRC had recorded these assets in its accounting records at a value of 139,000. Subsequent to our audit, in September 2014 SRC reported the loss to the Provincial Comptroller as required. The loss has not been included in the public quarterly reports on losses. That concludes my presentation.

The Chair: — Thank you, Mr. Schwab. Mr. Schramm, if I could open it up for you to make some comments.

Mr. Schramm: — Thank you, Madam Chair, committee

members. On the first point, board remunerations, in 2009 we had been endeavouring for nearly a decade to try and obtain authority to raise the honorarium remuneration rate of our board of directors, which hadn't been changed since the 1980s. The advice we were given at the time from people more knowledgeable than ourselves was that the Lieutenant Governor in Council could approve such a rate, but also we were advised that — treasury board and Executive Council advised us that — it was also possible to have these approvals obtained as a level D approval from treasury board. So we were able to receive such approval from the deputy minister of Finance serving at the time, who had been advised that he had the authority to do so, and by treasury board. And as a result of that, and with the judgment of our minister of the time, we implemented the new remuneration rates.

As you heard, during the 2014 year-end audit the Provincial Auditor informed us that it was their view that we actually did require specific Lieutenant Governor in Council approval for any changes to our board remuneration rate. At that point in time we were preparing a cabinet decision item for our cabinet to consider the possibility of making some changes to our board, as happens from time to time in the normal course of events, and we were advised that if we were to include the rates that we were proposing to pay and in fact had been paying at that point in time, in the order in council, under the financial implication section, that that would satisfy the Provincial Auditor and Executive Council and anyone else that might be a party to the authority. So we went ahead on that basis. It was approved by our minister of the time on to cabinet who approved it. The motion that went before cabinet contained all of the financial information.

As you heard, it was approved by cabinet on October 1st, 2014. In that particular case it ended up being written in by the Premier on behalf, acting on behalf of the Lieutenant Governor. So we know that the Premier would've been aware of this as well because it was fully disclosed in the cabinet decision item. But as you heard, the actual literal order in council didn't have the financial remuneration words in it. It only had the board appointment changes written in it, which was the Lieutenant Governor's prerogative.

So our thought on what to do going forward is the next time we make another set of recommendations to our minister and then it's on to cabinet for board changes, which we are working on and will be coming up in due course, that we try again. We can put the information in and but we'll still have to leave it to cabinet and ultimately the Lieutenant Governor which words they choose to use. So that's that issue.

On the losses not reported, as you heard, in 2009 certain biotechnology assets, physical assets that we'd decided were surplus to our business needs and which we were unable to sell in Canada, were sent to Firstenberg Machinery Co. in the United States in order to be hopefully sold under consignment. They had been thoroughly reviewed as to background, as we always do, and had a good reputation for selling niche biotechnology assets within the industry. And there was a target industry in the United States.

We followed up with the company periodically to assess interest and the potential to sell. During the 2013-14 year we attempted to contact Firstenberg again as part of our normal process, but by that point discovered that the company had filed for bankruptcy in September of 2013. So at some point between June 2013 and September 2013 it appears that the assets were actually sold, but they had not notified us. As the secured debt was greater than the assets of the company, unsecured creditors did not receive any remuneration. We were one of those.

We contacted the lawyer in charge of the bankruptcy proceedings who told us that the documentation surrounding the sale of our assets couldn't be located, but they had wanted to make sure we were appropriately listed as a creditor. We also inquired as to whether any investigation, charges, or lawsuits, or even suspicions had occurred as a result of the assets being sold prior to bankruptcy and clients not being notified. The trustees confirmed that there were none, that is, no charges, allegations, or suspicions of anything other than the bankruptcy. And as a result, we determined that the loss was due to bankruptcy and treated as a bad debt accordingly, which happens from time to time.

Our folks reported this to the Provincial Auditor's team during their audit fieldwork. At the end of the review of the file, the Provincial Auditor determined that the loss was the result of the sale of the assets without notification, which they stated was an illegal act and should have been reported. We disagreed with this interpretation and still do because we have no reason to believe fraud was created or perpetrated.

The Provincial Auditor included it as a management letter point, as you've already heard. We also disagree with the interpretation on the value. The number you heard of 139,000 is the correct value, book value, that was placed on the books. The fair market value of the assets, however, would have been much lower. This was used equipment which we were unable to sell in our local market. We had no expectation of getting a lot of money for it.

Evaluation of other assets had been undertaken during the year. Our best estimate is that in the best case scenario, the sale, had it . . . which apparently proceeded. The sale, had it proceeded there according to plan, would have netted about 10 per cent of the book value, which would bring it down to $13,900 and after paying 25 per cent fees we expected to, in the best case scenario, get $10,000, which we didn't get.

We submitted an incident of financial irregularity report to the Provincial Comptroller, however. We received a response from the Provincial Comptroller on October 20th, 2014 stating that the Provincial Comptroller agreed that the loss was due to bankruptcy and as a result would not be reported in losses of public money, 2014-15 second quarter report, as you also heard.

To ensure a similar situation doesn't occur in the future, our intention would be to try and avoid sending assets out of the country to another third party over which we have limited control unless we have no other reasonable recourse to try and recover value out of unneeded assets. So we'll try not to repeat this but I can't think of the last time we even had to do this, so it's not something likely to happen very often. But that's our best thought on how to prevent this, is not let the assets get into somebody's hands if possible, and then we would retain a little more degree of control.

The Chair: — Thank you, Mr. Schramm. I'd like to open up the floor for questions. Mr. Wotherspoon.

[09:45]

Mr. Wotherspoon: — Thank you very much, and thank you for the information here today. As far as the changes that were made to board compensation, that information, as you shared, has been approved by the cabinet, by the Premier. It just hasn't been published. Are you able to share that information, not necessarily today but in subsequent days with members of this committee?

Mr. Schramm: — The remuneration rates?

Mr. Wotherspoon: — Right.

Mr. Schramm: — Yes, absolutely.

Mr. Wotherspoon: — Thank you very much. On the second piece, the asset, obviously this is a challenging circumstance. Maybe to the auditor: it was noted that there was some different interpretations of whether this was an illegal act or whether this was a course of a business process. Maybe just to get some perspective from the auditor.

Ms. Ferguson: — Sure. One of the things that when we look at is like a normal course of practice is if you decide to ask somebody else to sell your assets, what you do from an accounting treatment right away is look at what do you think you're going to recoup from them, and you adjust your financial records at that point in time. And in this case they did not do that. And so we thought initially when they did the transfer, they must have really thought that those assets were worth $139,000 or else they would've adjusted their records immediately because that's normal accounting procedures. So that's why we use the 139 because that's what the management had recorded in their records.

On the other aspect, it's making sure that, you know, that they respect the requirements under the financial admin Act and if there's something that's a bit borderline, and this is one that we thought was a bit borderline, then you share that. You share that with the other agency. You generate, you initiate that discussion and allow them to make the decision as opposed to not sharing. And I guess, you know, in both cases here it's really a transparency and making sure things are shared outside of the organization as expected by the rules.

So in the first one, it's making sure that your approvals are in place, but also that it's made public as expected. So in both cases, it's sharing information outside of the organization as the rules expect.

Mr. Wotherspoon: — Would you care to respond?

Mr. Schramm: — Yes, but not to that. I would, thank you. On the auditor's first point that it would be better to recognize the probable value that could actually be realized, I think we agree completely that that is a better practice and we would endeavour to do that in the future, so no argument with hindsight. That's much clearer than it was at the time.

In terms of reporting and transparency, we have honestly felt that we reported everybody we should have in that we reported the incident to the Provincial Auditor field team and we reported it to the Provincial Comptroller. So we believed we were reporting to everyone that we needed to in good faith, and if there's somebody else we should report to, we just need to learn that.

Mr. Wotherspoon: — So of course any matter of, you know, public accountability and reporting out is important, so where's the discrepancy there? Is it the timeliness of when the reporting occurred or which report it wasn't contained in?

Ms. Ferguson: — Well on the latter one is that at the point in time for the matter with respect to the consignment of the goods, that incident wasn't reported until after the audit, until we raised it to their attention and it was done. As we made in our presentation, it was done subsequent and we, you know, it was . . . We thought that they should, and they did as an organization. As we indicated in our presentation, they did do that. So it's a timing thing, you know, and in terms of getting the order in council for their remuneration, you know, it's a 2009 decision that was initially made and then it's just taking a period of time to get that order in council and to make that remuneration public in that manner. So it's a timing issue.

Mr. Wotherspoon: — Is there a change in practice? I guess in the future if you were dealing with this circumstance in the future, would there be a change in how you would report this loss or this problem from a timeliness perspective?

Mr. Hill: — In the future if there's another grey area item such as this, we'll be talking to the provincial comptrollers immediately and basically leaving it up to the Provincial Comptroller's office as to whether they would like to see an incident report on it. We have filed incident reports on items that were grey area in the past. They were situations whereby there were no losses in public money but we still felt, you know, this is a bit odd, so we had talked to them about it and had filed a report. We were just quite certain on this one at the time that it was due to bankruptcy.

Mr. Wotherspoon: — And what was the actual asset? What was it that was being sold? And I guess you've suggested that you haven't been able to ascertain who it sold to or for what value.

Mr. Hill: — The specific items I can't recall off the top of my head but they were certain biotechnology assets. The value and the ability to be able to ascertain who it was sold to, the records in the company were not that great from what we heard, and that was part of the reason that led to the bankruptcy of the organization. And as a result of it, we haven't been able to determine who it was sold to or for what value.

Mr. Wotherspoon: — You've talked about some of the recourse that you've taken, steps and actions that you've taken since then and from a legal perspective. Are there any further steps or any further recourse to try to receive some value for this asset or to find out what it was actually sold for? Are there any other or is this a closed item at this point in time?

Mr. Hill: — In a situation of bankruptcy it's fairly difficult to

obtain any value, especially as an unsecured creditor. Generally within bankruptcies the secured creditors are greater than the assets and unfortunately in those situations, unless there's situations whereby there is negligence or fraud, it's almost impossible to go after the directors of the organization.

Mr. Wotherspoon: — And from the auditor's perspective, would the auditor's office identify any potential next steps by way of recourse or legal accountability on this front?

Ms. Ferguson: — Well I think in this case here, you know, we are, as management's indicating, they're thinking at the end of the day the value, the fair value of the assets is relatively modest and so the legal recourse, particularly given that it's out of country, will probably, the costs of that would probably outstrip the value of the assets. I think it's more of a, as you've heard, management's taking a lessons learned perspective and I think that's an appropriate perspective to take. And as auditors we think that what they're doing in that regard is an appropriate way to look at this situation because of the modest dollar amounts involved.

Mr. Wotherspoon: — I have no further questions. Thank you so much for the answers and the information and the actions here today.

Mr. Schramm: — If I may, on your earlier question of the specific nature of the equipment, I'm sorry. I don't have the specific nature in my head either but it would have been for fermentation processing so it would have been either fermentation equipment or work for subsequent processing of fermentation products and/or part of a fill and finish line. And I'm just a little fuzzy in my mind of which of the components this particular one would have been, but we can get it more specifically for you if you would like. But it would be one of those three buckets related to fermentation processing.

Mr. Wotherspoon: — I'm sure you have the actual asset and if you're able just to supply that information to the committee, that'd be great. Thank you.

Mr. Schramm: — We will.

The Chair: — Mr. Norris.

Mr. Norris: — Thank you, Madam Chair. Thanks very much for the presentation and explanation. Mr. Schramm, you highlighted that you'd look at not having equipment like this cross borders in the future. Can you elaborate a little bit on that? Would it have been easier to track or trace had it remained (a) within Saskatchewan or (b) within Canada?

Mr. Schramm: — What we were thinking with hindsight is we could have just left the equipment in Saskatoon and tried only to work through Canadian brokers to try and sort of display the nature and put it on the basis that if someone was interested and was willing to travel to come to where we are and see the equipment, then we could make sure that the equipment didn't go anywhere until suitable arrangements were in place.

The reason we didn't do it at the time is we felt that to attract . . . Because we'd already tried to sell it within the Canadian market, we felt to sell something in the United States that's of, again low value, the odds of someone being interested enough to be willing to travel all the way to see it and incur those costs might have prohibited any chance of a sale. So it's a question of which risks. So our thought was simply that if we could retain physical control over the assets we could prevent something like this from happening but the risk might be that we just can't sell it and end up writing it off and selling for scrap.

The Chair: — Are there any further questions? Mr. Michelson.

Mr. Michelson: — In the case of where you are soliciting someone to sell it out there, do we not check their credibility before we get into the actual of transaction of sending them our equipment and making the arrangements in that regard?

Mr. Schramm: — Yes, we do absolutely and we did that in this case. We checked out their background, their financial background, and also their reputation, all of which at that point in time were good.

Mr. Michelson: — Thank you.

The Chair: — Are there any further questions on these two recommendations in this chapter? Seeing none, what is the committee's will? Could I have a motion?

Mr. Doke: — Well thank you, Madam Chair. On the first recommendation no. 144 on chapter 24, we would concur with the recommendation and note progress towards compliance.

The Chair: — Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 24, that this committee concur with recommendation no. 1 and note progress to compliance. Is there any discussion on this? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Could I have a motion for the second recommendation?

Mr. Doke: — Thank you, Madam Chair. With chapter 24 and the second recommendation, we would concur with the recommendation and note compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 24, recommendation no. 2, that this committee concur with the recommendation and note compliance. Is there any conversation? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you to Mr. Schramm and Mr. Hill for your time before us here today. We appreciate the opportunity to ask some questions. And would you like to make any final comments?

Mr. Schramm: — Just two. One, thank you, Madam Chair and the committee. And the two pieces of information that we committed to provide this committee, I'm holding in my hands. We'll leave it with you or one of your officials before we leave. It's right here.

The Chair: — Thank you very much. And we'll just take a quick recess. We will recess while we change officials. We will not adjourn.

[The committee recessed for a period of time.]

Saskatchewan Liquor and Gaming Authority

The Chair: — Okay. Thank you very much. Welcome back, everyone. We are here now dealing with our second item of business, which is Saskatchewan Liquor and Gaming Authority. We'll be looking at the 2014 Provincial Auditor report volume 2, chapter 23, and the 2015 Provincial Auditor report volume 1, chapter 28.

We have with us here today Barry Lacey, the president and chief executive officer. Welcome, and welcome to your officials. I'll give you an opportunity in a moment to introduce everybody who is with you, but I will pass it off to the Provincial Auditor to make some remarks and then we'll go from there. Ms. Ferguson.

Ms. Ferguson: — Thank you. Madam Chair, Deputy Chair, members, and officials, I've got with me on my left Ms. Carolyn O'Quinn. Carolyn was recently promoted to a deputy provincial auditor in charge of the finance division in which the Saskatchewan Liquor and Gaming and also SIGA [Saskatchewan Indian Gaming Authority Inc.] are part of that portfolio. Behind her is Ms. Kim Lowe. Kim is our committee liaison.

Before we launch into the presentation of the two chapters before you, I just wanted to pause to thank the president and his staff for the co-operation that we've received during the course of our work. We certainly appreciate that.

We're going to present the two chapters that are before you in the order that they're presented on the agenda. You'll find that there's only one new recommendation in the two chapters and that's in the first one. Chapter 23 has one new recommendation for the committee's consideration. The committee has considered the remaining chapters that are presented. So without further ado, I'm going to turn it over to Ms. O'Quinn to present the first chapter.

Ms. O'Quinn: — Thank you, Ms. Ferguson. Chapter 23 of our 2014 report volume 2, which starts on page 139, reports the results of our annual integrated audit of Liquor and Gaming for the year ended March 31st of 2014. We report that the authority's 2014 financial statements were reliable. It complied with relevant authorities and it has effective rules and procedures other than the four matters noted in the chapter. On page 141, we report that Liquor and Gaming did not obtain sufficient information from its service provider, which is the Western Canada Lottery Corporation, Saskatchewan division, to record all of its purchases and disposals of slot machines and to keep its financial records up to date. As a result, Liquor and Gaming had not recorded the full value of 21 slot machines worth 500,000 in its financial records.

Up-to-date records are important to ensure Liquor and Gaming has accurate and complete information when making decisions. So we recommended that Liquor and Gaming verify on a timely basis information from its service provider on purchases and disposals of its slot machines to enable it to keep its financial records up to date.

On pages 141 and 142 of that chapter, we discuss three areas that were previously discussed with this committee. We note that at March 31st, 2014, Liquor and Gaming continued to need to develop policies and procedures to monitor IT [information technology] security and to respond to security issues when they arise, to implement its enterprise risk management framework, and to consistently comply with its user access IT policies and procedures. This concludes my overview of this chapter.

The Chair: — Thank you, Ms. O'Quinn. If I could pass it off to Mr. Lacey, would you like to make some comments on that particular chapter, chapter 23?

Mr. Lacey: — Yes. Thank you and good morning. Perhaps to begin with I'll just introduce the officials that I have with me here from SLGA [Saskatchewan Liquor and Gaming Authority] today. On my left is Tim Kealey, who's the chief financial officer and vice-president of the performance management division at SLGA. To my right is Jim Engel, vice-president of corporate services. Sitting behind me to my immediate right is Lee Auten, vice-president of the partnerships and supply management division at SLGA. Directly behind me is Chet Culic, director of SLGA's casino operations branch. And to his left is Rory Jensen, acting director of SLGA's financial services branch.

So we're pleased to be here this morning to discuss the Provincial Auditor's report in relation to the Saskatchewan Liquor and Gaming Authority and, after this session, the Saskatchewan Indian Gaming Authority. I'll begin by saying that SLGA accepts the Provincial Auditor's recommendations and we appreciate the work done by the Provincial Auditor.

Regarding the review of SIGA, SLGA and SIGA also accept the Provincial Auditor's recommendations and SLGA remains committed to work closely with SIGA to ensure the outstanding recommendations are addressed.

And with that, I'll just provide a few brief comments on the chapter the Provincial Auditor just spoke to. So with respect to the new recommendation on page 141 of the report — the recommendation being that SLGA verify information from its service provider on purchases and disposal of its slot machines — I can report to the committee that SLGA has put processes in place to ensure information from its service provider on purchases and disposals of its slot machines are verified on a quarterly basis, and as a result we believe this recommendation has been addressed and implemented.

With respect to the three, the outstanding recommendations from previous reports, the recommendation on page 41 that relates to SLGA developing security policies for monitoring IT security, we've taken a number of further steps to fully implement this recommendation including establishing an IT security governance committee whose responsibility is to review and revise all IT security policies at SLGA by the end of this fiscal year. So I would report that progress is being made to fully address this recommendation, and we expect to have it

addressed by the end of this fiscal.

The recommendation on page 142 where the Provincial Auditor speaks to recommending SLGA develop and implement an enterprise risk management framework and plan, I can report to the committee that work undertaken in 2014-15 leads to this recommendation having been implemented at SLGA.

And finally the recommendation you'll find on page 142, the recommendation related to SLGA following approved IT policies with respect to IT user access, SLGA has also taken a number of steps to address this recommendation but it continues to remain a work in progress. However, the plans we have in place for the remainder of this fiscal year, we believe that we will be in a position to report implementation of this recommendation by the end of the fiscal. That concludes my remarks on the specific recommendations under review. My officials and I would be happy to answer any further questions you may have of us. Thank you.

The Chair: — Thank you, Mr. Lacey. I'd like to open up the floor for questions. Does anyone have any questions? Mr. Wotherspoon.

Mr. Wotherspoon: — Maybe just thank you so much for identifying the actions that have been taken to ensure response and implementation of the recommendations — some of which have been implemented at this point in time, others that in the very near future, I believe you've communicated, will be fully complied with. So that's important.

Could you just give us from your perspective the risks that were present to the Saskatchewan people or to the organization had these recommendations not been addressed?

Mr. Lacey: — Okay, I'm going to let Jim Engel, vice-president of corporate services speak to that. Kind of the IT area is under his purview. So, Jim.

Mr. Engel: — Sure. Thank you very much, Barry, and thank you for the question. In terms of risks of the two questions that pertain to IT and access and security . . . So on a security perspective, I'll deal with that one first. Basically the risks that result from not having an adequate or robust enough security framework in place, it does leave some potential for SLGA's information technology systems to be vulnerable from external threats primarily. So either focused threats where someone is purposely trying to gain access to our systems or more widespread threats, viruses, those sorts of things that are in broader circulation globally.

Either one of those situations, if you've got a focused threat toward SLGA or a more general virus type of threat, the risk would be that those systems get compromised and some or all of our functionality is lost. So, you know, practically what that means for us from a business perspective, again worst-case scenario, if some of our systems were compromised it might mean that for a period of time the amount of support, for example, that our head office systems could provide to our point-of-sale systems in the store might be less than ideal.

Now in that context we do have structures and systems in place where our stores can actually operate independently for up to three days if necessary, completely disconnected from head office. But if there were to be a more catastrophic failure of head office systems, for example, that would extend beyond three days, then we may run into some issues about whether head office can properly support daily point-of-sale transactions in the stores.

Potentially as well on some of our internal systems . . . Again if systems, either hardware or software, are compromised it may impact our ability to carry on normal day-to-day functioning within the organization. So processing invoices, dealing with accounts payable, those sorts of things. So that would generally be the nature of the risks that we face, the internal operations or the service to customers.

Mr. Wotherspoon: — Thanks so much. And I guess just to follow up then, have you had any focused attempts or any actual breaches of information?

Mr. Engel: — To date we have not. We have not had any focused attempts that we're aware of where someone has specifically targeted to try to gain access to SLGA systems.

We, like any other organization or even individual, are constantly inundated with spam and viruses that are just circulating out in the global community that are looking for a place to land. I know our IT director has told me that in any given day — and again, apparently this is not out of the norm — in any given day, about 70 per cent of the email coming into the organization is actually blocked from coming into the organization. Just to give a sense of scale there that well over half of the normal flow of email messages and contact coming into the organization are actually either potentially or are threatening. And again I gather just that's the norm out there in the world right now. So I think that is another aspect to the question, or does that cover it?

Mr. Wotherspoon: — No. Thank you very much. I appreciate the information.

The Chair: — Are there any further questions on this particular chapter? Seeing none, we have one new recommendation with which we . . . Oh, Mr. Michelson. My apologies.

Mr. Michelson: — Thank you. And you know, it's almost irrelevant but when you talk about the disposal of slot machines, what happens to them? Like, could I get one for my rec room or . . .

[10:15]

Mr. Lacey: — So with respect to the slot machines, I'm told that when they are deemed to be no longer needed in the casinos that they are, they're offered up for sale. But they're only offered up for sale to an authorized organization who is authorized to legally purchase those machines. If there are no takers on the older slot machines, then they actually go to a crushing facility where the machines are actually crushed, And the crushing of those machines are monitored by SLGA to ensure that the machines are destroyed.

Mr. Michelson: — Thank you. Just Mr. Hart was interested because . . . But he figures there's a big enough gamble in

farming so he doesn't need one. Thank you.

The Chair: — Thank you, Mr. Michelson. Are there any further questions on this particular chapter? Seeing none, we have one new recommendation with which we need to deal. Can I have a motion, please?

Mr. Doke: — Thank you, Madam Chair. In regards to the 2014 Provincial Auditor report volume 2, chapter 23, we would concur with the recommendation and note compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 23, that this committee concur with the recommendation and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Moving on to the next chapter, I shall pass it off to our Provincial Auditor for her comments.

Ms. Ferguson: — I'm going to keep passing it along here.

Ms. O'Quinn: — Thank you. I'm now moving on to chapter 28 in our 2015 report volume 1, which starts on page 279. This chapter reports on the results of our follow-up of some 2006 recommendations relating to Liquor and Gaming's processes for encouraging responsible use of beverage alcohol. We are pleased to report that by February of 2015, SLGA had fully implemented our remaining recommendation related to performance measures and targets to evaluate its performance in encouraging responsible use of beverage alcohol. That concludes my remarks.

The Chair: — Thank you, Ms. O'Quinn. Mr. Lacey, do you have any comments?

Mr. Lacey: — No, I have no further comments other than to comment we are certainly pleased at SLGA to have closed off this recommendation. Thank you.

The Chair: — Thank you. Are there any questions on this particular chapter? Seeing none, we don't actually . . . There's no new recommendation, but could I have a motion to conclude considerations?

Mr. Doke: — So moved, Madam Chair.

The Chair: — Mr. Doke has moved, for the 2015 Provincial Auditor report volume 1, chapter 28, that this committee conclude considerations. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Moving on to SIGA now. I will pass it off to the Provincial Auditor for her comments on the 2014 Provincial Auditor report volume 2, chapter 22.

Saskatchewan Indian Gaming Authority Inc.

Ms. Ferguson: — Thank you very much, Madam Chair. For these two sets of chapters, what we're just going to do is present them in the order that they are presented on the agenda, pausing after each. There is no new recommendations for the committee's consideration contained in these so I'm just going to continue. Ms. O'Quinn will present the first chapter here.

Ms. O'Quinn: — Thank you. Chapter 22 in our 2014 report volume 2, which starts on page 133, reports the results of our annual integrated audit of SIGA for the year ended March 31st of 2014. We worked with SIGA's appointed auditor, which is Deloitte, in carrying out this audit. We report that SIGA's 2014 financial statements are reliable. It complied with relevant authorities and it has effective rules and procedures other than the four matters that we highlight in the chapter.

While SIGA had made some good progress, we note that at March 31st, 2014, SIGA continued to need to assess the need for a business continuity plan, complete and implement its human resources plan, perform regular reviews of its computer application user accounts, and follow its policies to control its capital assets. The chapter also reports that SIGA implemented one prior recommendation related to segregation of its IT responsibilities. That concludes my remarks on this chapter.

The Chair: — Thank you, Ms. O'Quinn. Mr. Lacey, would you like to make some comments on chapter 22?

Mr. Lacey: — Yes, thank you. As noted by the Provincial Auditor, there's no new recommendations in the chapter but I will speak to some of the work that SIGA's done over the last year with respect to the outstanding recommendations.

With respect to the recommendation on page 135 regarding SIGA's preparation of a complete disaster recovery plan and assessment of the need for a business continuity plan, we can report that SIGA has provided SLGA with its emergency and continuity management plan in June of 2015, so this spring. And with that, with the disaster recovery plan and that emergency continuity management program now in place, we believe this recommendation has now been addressed and implemented.

The recommendation on page 136 that relates to SIGA should complete and implement its human resources plan, SIGA has since completed its workforce plan and the SIGA board has approved the plan at its November 2014 meeting. And SIGA also continues to address action items that were identified in that workforce plan. So we also believe that this recommendation has been addressed and implemented.

The recommendation that SIGA should perform regular reviews of its computer application user accounts, which can be found on page 136, SIGA's working to fully comply with this recommendation and expects to fully address it by the end of this fiscal year.

And finally, with respect to the recommendation that SIGA follow its policies to control capital assets, which can be found on page 137, SIGA has performed a count on some of its assets, but it's not carried out a complete account on all capital assets as its casino policies require. And what SIGA's doing is it's currently doing a risk-benefit assessment of counting all of its inventory. And we expect that SIGA will finish this risk-benefit

assessment this fiscal year. And hopefully, whatever that outcome of that assessment is, we'll be in a position by the end of this fiscal year to say the recommendation's been addressed.

That concludes my remarks. Thank you.

The Chair: — Thank you, Mr. Lacey. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Thanks to the auditor for the recommendations. Thanks to SLGA and to SIGA for the actions taken to address these recommendations. I'd appreciate just hearing briefly from the auditor as to, from their perspective, the adequacy of these measures that have been taken and the actions that, you know, certainly suggest that recommendations will be implemented very soon in most cases.

Ms. Ferguson: — As management has indicated, we are seeing progress on each of these recommendations. There are some of the recommendations, as you can appreciate, are a little bit more complex, and the IT ones, there are some interrelationships between them. So you know, as an office we recognize that and so what we are as, you know, as always we look as to whether or not they're chipping away at it and making progress. And in this case we are certainly seeing that.

Mr. Wotherspoon: — Thank you for that. I have no further questions at this point, but certainly we appreciate the actions that have been committed to and that, you know, we'll follow up and track the progress. So thank you.

The Chair: — Are there any further questions on this chapter? Seeing none, we have no new recommendations with which we need to deal so I just need a motion to conclude considerations.

Mr. Doke: — So moved, Madam Chair.

The Chair: — Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 22, that this committee conclude considerations. Any questions? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. We shall move on to the next chapter. Ms. O'Quinn.

Ms. O'Quinn: — Thank you. Chapter 53 of our 2014 report volume 2, which starts on page 391, reports on the results of our follow-up of four recommendations that we initially made in 2012 on our audit of SIGA's IT threat and risk assessment processes.

We note that by August of 2014 SIGA had made some progress on two recommendations but still had more work to do. Because the last two recommendations are dependent upon the implementation of the first two, SIGA had not yet made progress on those.

We continue to highlight four areas of concern related to SIGA's IT threat and risk assessment processes. These are outlined on pages 392 and 393.

First, SIGA still needs to fully document and approve its plan for assessing the risks to its business from vulnerabilities to its IT systems. SIGA developed a process map for IT risk identification and assessment, but the information was not complete and guidelines for risk assessment had not yet been developed.

Second, SIGA needs to follow its policies by documenting its analysis of the impact and likelihood for its IT risks and developing responses for significant risks. By August 2014 SIGA documented its analysis of the impact and likelihood of IT risks. However, it had not yet determined its planned responses to those risks.

Third, as SIGA's IT risk assessment was not complete, it had not yet begun to report to senior management on IT risks.

Fourth, SIGA had not yet reviewed the effectiveness of its IT risk assessment processes on an ongoing basis. That concludes my presentation of this chapter.

The Chair: — Thank you, Ms. O'Quinn. Mr. Lacey.

Mr. Lacey: — Yes, thank you. With respect to the outstanding recommendation that SIGA needs to fully document and improve its plan for assessing risks to its businesses for IT systems, which is outlined on page 392 of the auditor's report, SIGA continues to work towards addressing this recommendation fully. They've devoted additional resources to it to get it done, and we're expecting that implementation of this recommendation will occur very soon, later this fall.

With respect to the recommendation that SIGA needs to document its analysis of IT risks and develop responses for those risks as outlined as well on page 392, SIGA has identified its IT assets and their value and has undertaken a risk and threats assessment on those assets. SIGA has submitted a draft risk registry to the IT management team for their review and SIGA's IT management team will finalize the risk registry later this fall. With finalizing that risk registry, we believe that the recommendation will be addressed. So we're looking at the recommendation being implemented later this fall.

As Carolyn noted earlier, many of these recommendations tie together. The work ties into all of the recommendations. So the recommendation that SIGA needs processes to report significant IT risks to their senior management team is reported on page 393. With that risk registry when it's finalized, it'll be reviewed by management and once that occurs we believe that this recommendation will be addressed once again later this fall.

And then finally with respect to the recommendation that SIGA assess its IT risk management processes and monitor those risks on an ongoing basis as outlined on page 393, you know, as the plan has not been implemented there is nothing to go back and review. So that recommendation will be addressed once SIGA has that IT risk registry in place, and say a year has passed. And then that would be the appropriate time for them to go back and review whether that registry has been an effective process for them. So we expect that that recommendation will be addressed in the next year.

That concludes my remarks on this chapter. Thanks.

The Chair: — Thank you, Mr. Lacey. I'd like to open up the floor for questions. Mr. Norris.

Mr. Norris: — Thanks very much. As we're talking about enhancing capacity, do you think there is sufficient capacity within the board and executive levels to be able to continue this and keep this momentum on?

Mr. Lacey: — You know, I think when you look at the history of SIGA, they as an organization have matured greatly over the years. And I think that's fair to say of their senior management team and of the board and of their governance structures, that there has been maturity that we have seen grow over the years.

And you know, I noted when I was going through the auditor's two reports here today is we're not talking about what I call financial controls, basic controls of an organization that you would expect an organization to have in place. Perhaps we had those conversations here five or six years ago, but we very rarely have those conversations here today. And so I think that it speaks to the growth of the skills sets and experiences at SIGA.

And so the recommendations here are really about higher level governance issues, higher level control issues that I think even mature organizations at times are challenging to address just because of their nature.

You know, I think SIGA is committed and from what I've seen is committed to continually improve as an organization and where they see gaps in their skill sets and resources, that they go out and they either bring that talent and expertise in internally, or they go out and get that talent through a consulting contract or some type of third party that brings it to the table.

[10:30]

So you know, my assessment would be on that is that yes, there's still opportunity for growth at SIGA, but certainly I think they're committed to addressing where those gaps exist. And we've seen concrete steps taken by them over the years to just do that.

Mr. Norris: — Terrific. I really appreciate the update and appreciate the work that's under way.

The Chair: — Are there any further questions on the chapter? Mr. Wotherspoon.

Mr. Wotherspoon: — Sorry. I was in and out of some of the pieces, but certainly I've tracked the progress updates that are here and the member's question, and I'm thankful of the work of the auditor on this front. There is a substantial amount of work still to occur and, you know, we see deadlines coming around for most of them here very soon in the fall of this year. One of them, the final outstanding recommendation, is still a little more than a year away. How confident are you that those timelines will be met?

Mr. Lacey: — I'm going to ask Lee Auten who is responsible for that area of our operation to respond to that question. Thank you.

Ms. Auten: — We're very confident they'll be able to meet the timelines. When you stepped out of the room, the conversation was around needing these processes to be put in place and then the last action item was to actually see them in action. They'll be able to review them and do their assessment at that time.

Mr. Wotherspoon: — Thank you very much.

The Chair: — Are there any further questions on this chapter? Seeing none, as there are no new recommendations, I just need a motion to conclude consideration.

Mr. Doke: — So moved, Madam Chair.

The Chair: — Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 53 that this committee conclude considerations. Any other discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Lacey, would you like to make any final comments?

Mr. Lacey: — No. Thank you for the questions of the committee here today and our opportunity to respond to them. Thank you.

The Chair: — Thank you very much for your time, and to you and your officials, enjoy the rest of your day.

And we will take a brief recess while we change officials. I'm not sure if our next set of officials are here yet, so please stand by.

[The committee recessed for a period of time.]

Public Service Commission

The Chair: — Welcome back, everyone. We are going to be dealing with two chapters of the Provincial Auditor's reports looking specifically at the Public Service Commission. Welcome to Marlys Tafelmeyer and your officials here today. I shall pass it off to the auditor for her comments, and then I will leave it to you to make some comments as well. So Ms. Ferguson.

Ms. Ferguson: — Thank you, Madam Chair, Deputy Chair, members, and officials. I'm just going to quickly introduce who's with me here this morning. Mr. Victor Schwab is back to make this presentation. He'll present both chapters. Behind is Ms. Regan Sommerfeld. Regan, as I mentioned earlier, was recently promoted to a deputy whose responsibilities include Public Service Commission; and Ms. Kim Lowe who is our office's liaison with this committee.

We're going to present the two chapters in the order that they're listed on the agenda, pausing after each. Each are very brief presentations because the chapters themselves are both brief. There is no new recommendations for the committee's consideration in either chapter, so without further ado I'm just going to turn it over to Mr. Schwab here.

Mr. Schwab: — Thank you, Ms. Ferguson. Chapter 17, beginning on page 107 of our 2014 report volume 2, reports the results of our annual integrated 2013 audit of Public Service Commission. We report that PSC [Public Service Commission] has complied with related authorities and had effective rules and procedures with one exception related to the removal of user access. We found that PSC did not always follow its processes for promptly removing user access for individuals who no longer work for PSC. Not promptly removing user access of former employees increases the risk of inappropriate access to PSC systems and data. On page 108 we continue to recommend PSC follow its established procedures for removing user access to its computer systems and data.

The Chair: — Thank you, Mr. Schwab. Ms. Tafelmeyer, if you'd like to introduce your officials and make any comments.

Ms. Tafelmeyer: — Thank you very much. Good morning everyone. It's a pleasure to be here with you today and provide you with an update on the Public Service Commission's progress in addressing the recommendations. My opening remarks will actually reflect both recommendations from the Provincial Auditor, first in the 2015 report volume 1, chapter 25 and the 2014 report volume 2, chapter 17.

I would like to begin by introducing the officials that I have with me here this morning. To my left, Raman Visvanathan, the executive director of our business services area; and to my right, Gisele Fontaine, the director of recruitment and talent development. And in opening I'd also like to acknowledge the work of the Provincial Auditor. We certainly appreciate your recommendations and are continuing to work towards improving in areas identified in the reports.

Let me first of all begin with the 2015 report with respect to the out-of-scope staffing. Volume 1, chapter 25, here the Provincial Auditor made two recommendations. I'm pleased to advise that both recommendations have been fully implemented.

Regarding the minimum documentation requirements, the Public Service Commission created an online staffing process road map which is a set of step-by-step instructions for use by our hiring managers which identifies the file requirements for each step of the staffing process. A file requirements checklist has also been created to supplement that road map.

Now in the area of risk-based processes, to confirm that essential documentation is on file, the Public Service Commission has implemented a staffing file review process whereby 10 per cent of our completed staffing competitions are reviewed on a monthly basis. Now this review ensures that due diligence is given to the staffing process, that essential documentation is maintained, and that hiring managers fulfil their responsibility for staffing in accordance with *The Public Service Act*. Now our human resource consultants continue to support, consult with, and advise ministry management throughout the staffing process.

Now moving on to the 2014 report, which was referenced a few moments ago, volume 2, chapter 17. We certainly recognize the importance of timely removal of user computer access. And some of the actions we have taken to date include, firstly, communication and reminders to our managers and administrative staff of the importance of timely removal and what the expectations are as set out by the auditor's office.

Secondly, we do have a checklist in place for managers which have been updated to include this task as one of the items to be completed when employees do leave the organization.

Thirdly, we do receive computer access reports, and those are reviewed on a regular basis to determine exactly what action is necessary to meet the standards. We certainly acknowledge that the timely removal of user access has not yet been fully implemented. However, we do continue to work to improvement.

We are pleased with the progress we've made on these recommendations, and we'll continue to work towards further improvement. And with that, I'm happy to answer any questions that the committee members may have.

The Chair: — Thank you, Ms. Tafelmeyer. I'm just going to pass it off to the Provincial Auditor before we ask questions, just so we've got some context for the chapter 25 of the 2015 report.

Ms. Ferguson: — So really it's just to . . . You know, the information that the officials just presented does reflect what's in the chapter there. They have fully implemented a recommendation that we initially made in 2011, and we're very pleased with the approach that they have put in place to address that recommendation. So that concludes our comments.

The Chair: — Thank you. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Thank you very much for the information today and the report, as well as the actions to address the concerns that have been noted by the auditor. Certainly those are important actions that you're taking.

I'm wondering, at the same time here, if I could ask a question as it relates to the data that's being collected around retention rate of those in the Public Service Commission. And I note a chart that, I believe, is a ministry document that cites that from 2008-09 the retention rate used to be 64.2 per cent; in 2013-14, that it's 50.4 per cent. So a reduction of about 14 per cent. I'm wondering if you have any further data and if you have any analysis as to the cause of this decline?

Ms. Tafelmeyer: — Thank you very much. I believe the retention rates that are being referenced is in relation to the retention of what we consider four-year hires. So upon hiring, four years later are those individuals still within the organization? And the 2013 statistics was approximately 50 per cent of those hired four years ago were still with the Government of Saskatchewan.

[11:00]

Some of the factors influencing this certainly is the competiveness of the market in terms of salary and total compensation — some of our biggest competitors of course, with the private sector and the growth in the mining sector and in potash, oil for example — and as well some of the growth

occurring in the Crown sectors. So those are some of our biggest competitors that have certainly impacted on the retention rate, particularly of new hires.

Mr. Wotherspoon: — Thanks for that information, that analysis. I am also aware that your ministry conducts broad workplace satisfaction reviews or surveys. I'm not sure what the proper term of this is. I guess, could you share what those are called and where the public could access those reports.

Ms. Tafelmeyer: — The employee engagement surveys, I believe, is what you're referring to. We have encouraged each ministry to conduct an employee engagement survey. We have what we consider a standard set of questions that we are able to benchmark then the results against interjurisdictional comparisons across Canada.

Ministries are encouraged to undertake a survey approximately every 18 to 24 months. So it does vary by ministry. And in terms of the access to those results, they are ministry results which have not been made public, but they are certainly shared with the respective ministers.

Mr. Wotherspoon: — Would it be possible to have those reports shared with the members of this committee?

Ms. Tafelmeyer: — Certainly let me take that back for some consideration and advisement.

Mr. Wotherspoon: — Thank you. And would you be able to note any trends? Do you have any analysis that you'd be able to share as a result of those surveys?

Ms. Tafelmeyer: — Certainly. And one of the encouraging notes is an analysis we just completed. In comparison to the other jurisdictions we're actually trending, Saskatchewan is trending above the public service averages for other jurisdictions.

Mr. Wotherspoon: — I'm sure it's important, well I know it's important information, and thanks for your attention to it. And I respect that you're considering how you might be able to share that information with members of this committee. So thank you very much.

The Chair: — Mr. Norris.

Mr. Norris: — Thanks very much for the work that's under way. The issue of access continues to come up across government and actually well beyond government. Just wondering is there a catalytic role to be played here to say, are there not simply processes and procedures which should continue but are there some technological options to help ensure that access is limited as people leave the public service? And it just seems to me that with enhanced technology that this, I'm not saying it would be easy, but perhaps could be better regulated or at least better understood as a phenomenon?

Ms. Tafelmeyer: — Certainly you raise an interesting point. And certainly one of the challenges that we face in maintaining an efficient as well as the timely removal of access is the number of computer systems that employees actually have access to, particularly within the Public Service Commission. There's actually three separate systems and they're managed by three separate ministries. So for example we have MIDAS [multi-informational database application system] human resources which is managed by the Public Service Commission; MIDAS financials managed by the Ministry of Finance; and then the network access and email access managed by the Ministry of Central Services. So removing the access in a timely fashion means coordination among those ministries.

In addition though, steps are taken very quickly to remove access to remote systems as well — so being able to have remote access, working off-site, but in addition access to the building itself, their workplace. So by removing those two accesses immediately also limits the risk and reduces the likelihood that further access will occur if we're unable to remove the timely access on those three systems.

Now in terms of some further technological advances I'll maybe turn to Raman to see if he can add some further insight to that.

Mr. Visvanathan: — Yes. We have had some brief discussion about this, both the turning access on as well as turning access off. As Marlys indicated, there are three service desks that need to receive a request to turn access on to the network: HR [human resources] financials, HR human resource, or the MIDAS human resources. If there was an electronic fillable form that somebody went onto a SharePoint site for example, filled in all of those details, and then behind the scenes the service requests get directed to the service desk, the service desk could fulfil that. At the same time, upon resignation or separation from government, a similar process was carried out and electronic service requests directed to that, that would avoid managers having to do that. And I think the traditional issue is it's simply a matter of oversight that the service request isn't submitted on a timely basis.

Some of the things that we have been doing is encouraging the use of a manager checklist. There's two primary sections to that, one that says these are the things that a manager should do when the notification for termination has been received. Sending a service request in, in advance with a particular date when access should be removed to coincide with their last day of employment, is one of the best ways I think that we can encourage managers to fulfil the requirement to have access turned off on the last day of employment. But we have sort of explored that in a modest way in terms of the technology. We would need to build that technology. The Public Service Commission is developing a system that we call the PSC Client, and we're optimistic that that might allow us that kind of functionality.

Mr. Norris: — Great. Thanks very much for the update.

Mr. Visvanathan: — Okay. Thank you.

The Chair: — Ms. Ferguson just has a comment.

Ms. Ferguson: — I know it's kind of subtle, but one thing you may not have noticed in our reports, we actually make a distinction between access to the computer network and to the applications. We're trying to make that distinction because we recognize that really shutting down that network access is

pivotal, you know. And if it's a little bit more delay on the application the risks are lower but, you know, your higher risk is if you don't get that network access shut off in time. So in our findings you'll see that we're starting to split that out a little bit better than we had done earlier.

Our testing has always been on both levels, but I think our reporting is, we've nuanced it just so that, you know, I think it's better information to reflect the risks that are presenting.

The Chair: — Are there any further questions on either of these chapters? Seeing none, as there are no new recommendations, I think I could have a motion to conclude consideration on both chapters. Is that agreed? Or is that, could I have a motion?

Mr. Doke: — So moved, Madam Chair.

The Chair: — So moved. Mr. Doke, has moved that this committee conclude consideration of the 2014 Provincial Auditor report volume 2, chapter 17 and the 2015 Provincial Auditor report volume 1, chapter 25. Are there any further questions or comments? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. That concludes our work today on the Public Service Commission. Thank you to Ms. Tafelmeyer and to your officials here today. Thank you for your time, and we will take a quick . . . Oh, would you like to make any comments, Ms. Tafelmeyer?

Ms. Tafelmeyer: — Just in terms of concluding remarks, again our appreciation to the Provincial Auditor's office. They've been very supportive in the work that we've undertaken regarding improvements in these two recommendations, and thank you for your time this morning.

The Chair: — Thank you very much. We will take a brief recess while we bring the next officials in.

[The committee recessed for a period of time.]

Parks, Culture and Sport

The Chair: — Welcome back to Public Accounts, everyone. We're now going to take a look at the next item on the agenda, which is the Ministry of Parks, Culture and Sport and the two Provincial Auditor reports. We have here today the deputy minister, Ms. Lin Gallagher, and I'll give you an opportunity in a moment to introduce your officials, but I shall pass it off to the Provincial Auditor to give her remarks on the first chapter that we're dealing with.

Ms. Ferguson: — Thank you, Madam Chair, Deputy Chair, members, and officials. Before us we've got two chapters on the agenda. We're going to present the chapters in the order that they're listed. Before I do that I just want to do two things, introduce who I have with me today. Ms. Rosemarie Volk, Rosemarie is a principal in our office and she's led the work that's before you today. Behind her is Ms. Regan Sommerfeld. Regan's a deputy, recently a deputy that's responsible for this area, and Ms. Kim Lowe that is our committee liaison.

Before we launch into the presentations, I'd like to thank the deputy minister and her staff for the co-operation that we received in the course of the work that's before us today and work otherwise too. So with that, I'm going to turn it over to Rosemarie to present the first chapter that's listed on the agenda.

Ms. Volk: — Thank you, Ms. Ferguson. Chapter 16 of our 2014 report volume 2 contains the results of our annual 2014 audit of the Ministry of Parks, Culture and Sport and five of its agencies and two special-purpose funds, each with the March 31st year end.

We report that the 2014 financial statements of those agencies and funds are reliable, that they and the ministry complied with authorities governing their activities. In addition we report the agencies and snowmobile fund had effective rules and procedures to safeguard and control their assets. With respect to the ministry, we report that it had effective rules and procedures to safeguard and control its assets other than the two matters reflected in the two new recommendations.

On page 104 we recommended that the Ministry of Parks, Culture and Sport follow its established procedures and promptly remove unneeded user access to its computer systems and data. We found that the ministry did not follow its established procedures for removing user access to its computer systems and data. In one instance, the ministry removed an individual's network access about 73 days after the last date of employment. Not promptly removing IT user access of former employees increases the risk of inappropriate access to the ministry's systems and data.

On page 105, we recommended that the Ministry of Parks, Culture and Sport record, in its accounting records, the estimated cost of closure and post-closure care of landfills located in provincial parks. We found that the ministry had not recorded its estimate of liability related to the decommissioning of its landfills. In 2013 and '14, while the ministry estimated that the costs related to future closing activities for its landfills at $1.6 million, it did not record this estimate in its accounting records. Not recording accounting entries leads to producing incorrect financial information for decision making.

In addition, we report that the ministry, when it renewed its agreement with its lotteries agent, included the requirement to provide an annual payee list to the ministry. That concludes my presentation on chapter 16.

The Chair: — Thank you, Ms. Volk. Ms. Gallagher, if you'd like to make some comments on chapter 16.

Ms. Gallagher: — Yes. Thank you very much for the opportunity to present to you today. I'd like to introduce the officials that are here with me today: Twyla MacDougall, our assistant deputy minister of the parks division; Leanne Thera, the executive director of policy, planning and evaluation is behind me; Lynette Halvorsen our director of corporate services. We have Byron Davis with us, the park facilities branch; and Elizabeth Verrall, a senior policy analyst with our recreation and sport and stewardship division.

So I would like to respond to the items that were spoken to. The

first one around timely removal of user access, according to chapter 16 of the auditor's report, it did observe that we weren't consistently following its established procedures to promptly remove user access to the computer systems. The ministry recognizes that this is a risk that it places on our ministry systems and data, and we are working towards implementing the auditor's recommendation. The ministry has emphasized the importance of timely removal of access at our senior management table, as well as sending out employee service centre checklists and reminders to its managers who hire summer students, which is a particular challenge in our ministry.

Additionally, the ministry has begun running a report on a weekly basis to identify terminated employees to ensure that appropriate service request has been completed. We trust that these steps will improve the ministry's performance in this area.

For the second item, the recording of landfill remediation estimates needed, in 2014 the auditor recommended that the ministry record estimated cost for the remediation of landfills located in the provincial parks. The ministry has fully implemented the Provincial Auditor's recommendation. The ministry recorded the landfill liability in March 2015 and will continue its work with landfill decommissioning. The liability will decrease over time as the work is completed. This closure and post-closure work will be completed over a period of approximately five years.

In regard to the last item that was mentioned around the amended lottery agreement, the 2011 Provincial Auditor's report recommended that an amendment be made in the next lottery agreement to require Sask Sport to make payee lists available to the Ministry of Parks, Culture and Sport. The 2014 auditor's report confirms this recommendation has been implemented. The ministry's senior management annually reviews the Saskatchewan Lotteries payee lists for payments over $50,000. We have taken steps to strengthen our stewardship and oversight of the lottery system, and all lottery oversight recommendations made by the Provincial Auditor that were outstanding have been addressed.

The Chair: — Thank you, Ms. Gallagher. If I could open up the floor for questions. Are there any questions on these two chapters? Mr. Michelson.

Mr. Michelson: — When you talk about decommissioning a landfill, what is all involved with the decommissioning? Can you just describe that a little bit for us?

[11:30]

Ms. Gallagher: — Maybe I'll have Byron come up and speak to that. You know, I worked previously in the Ministry of Environment, so there's a lot of technical pieces. Maybe Byron can just give you a quick summary of that.

Mr. Michelson: — I appreciate that.

Mr. Davis: — Yes, thank you. Currently of course the provincial parks have moved away from operating landfills within the parks themselves, and we've moved more to a container system with agreements with regional landfills for hauling outside of parks.

So with the actual decommissioning work, it involves a . . . It's done in accordance with *The Municipal Refuse Management Regulations* under the Ministry of Environment. And the method typically involves cleanup of any recyclable materials, sorting at sites and that type of thing; infill of any existing pits; also an engineered clay cap system that includes a geotextile mounded clay cap to divert rain water. And then the post-closure activities involve installation of monitoring wells, which are monitored regularly over a period of up to five years to ensure there's no leaching.

Mr. Michelson: — Thank you.

The Chair: — Mr. Doke.

Mr. Doke: — Am I to understand then that recommendation no. 2 has been implemented?

Ms. Gallagher: — Yes, it has been.

Mr. Doke: — Okay. Thank you.

The Chair: — Are there any further questions on this chapter? Mr. Norris.

Mr. Norris: — Thanks very much. I just wonder if we can get a little bit more information on the provisions of securing that water and water monitoring that you've just highlighted?

Mr. Davis: — Well the monitoring wells are installed as a part of the decommissioning process just to ensure that there are no foreign substances and so on that leach away from the landfill area.

We've been very fortunate in the parks system that the closures we've done in the past have all been clear after a period of a few years, and monitoring then is no longer required if you're clear of any contaminants after a period of five years typically.

Mr. Norris: — How many wells? Just a ballpark, what are we dealing with?

Mr. Davis: — Yes. It depends on, I guess the size of the landfill, but typically there could be four or six monitoring wells around the site, just small monitoring wells, where samples are taken I think twice a year. I believe that's correct.

Mr. Norris: — And who would undertake the actual work of the monitoring?

Mr. Davis: — Well the testing has been done, it can be done by ministry staff in terms of getting the samples, but the tests are always done by a certified laboratory. So the testing is done and recorded and Environment is advised of our results.

Mr. Norris: — Great. Appreciate the thorough work. Thank you.

The Chair: — Mr. Michelson.

Mr. Michelson: — What kind of a radius would that be if

you're monitoring wells from the landfill or the . . .

Mr. Davis: — It's typically in the immediate area of the landfill to, you know, in the landfill site itself but outside of the particular landfill area.

Mr. Michelson: — Five hundred meters?

Mr. Davis: — Not even that far. It would be probably under 100 meters from the site itself to ensure that nothing is leaching away.

Mr. Michelson: — Thank you.

Ms. Gallagher: — So just to qualify. If we were to find that there was leaching, then there would be additional studies to determine the extent and if there was any remediation required for that. But as we've mentioned in our parks, our landfills, we've been fortunate that that hasn't been an issue.

Mr. Michelson: — Thank you.

The Chair: — How many landfills are we speaking of in that?

Mr. Davis: — We are currently looking at five major landfills that are to be decommissioned. We've decommissioned several to date.

The Chair: — Okay. Thank you. Mr. Wotherspoon.

Mr. Wotherspoon: — Just thanks for the actions on this front. These are tremendous assets, these parks. And appreciate the recommendations very much from the auditor and the actions outlined by the ministry to ensure full implementation of those recommendations. So thank you for the work.

The Chair: — Are there any further questions on this chapter? Seeing none, we have two recommendations, new recommendations, with which we need to deal. Can I have a motion?

Mr. Doke: — Thank you, Madam Chair. In regards to the 2014 Provincial Auditor report volume 2, chapter 16, recommendations 1 and 2, we would concur with the recommendations and note compliance.

The Chair: — Thank you Mr. Doke. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 16 that this committee concur with recommendation no. 1 and 2 and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. We'll move on to the next chapter, chapter 24, and I'll pass it off to Ms. Volk.

Ms. Volk: — Thank you. Chapter 24 of our 2015 report volume 1 contains the results of our second follow-up of the three outstanding recommendations initially made in our 2009 audit of the ministry's processes for provincial parks capital asset planning. By January 2015 the ministry had made some progress on these recommendations.

As reported on page 266, by January 2015 the ministry had identified some general trends that it uses when considering expanding and upgrading park services. However its plan did not set out specific projections about the level of demand or its intention to meet those demands, as we had recommended. Better information about projected future demand would help decision makers assess the resources required to upgrade the capital assets in the provincial park system. It would also help the ministry assess whether capital assets have adequate capacity for the long term. The ministry is expecting its new enterprise asset management system will help to develop a complete plan.

Also as reported on page 266, the ministry has set out general principles in its 2015-16 parks capital infrastructure plan. It planned to use its new enterprise asset management system to analyze asset conditions and the level of use. However it had not yet created a more detailed set of principles to guide how the ministry operates and maintains key capital assets at a reasonable cost and without unplanned service disruptions. More detailed principles will help staff analyze the condition and levels of use of assets, and prioritize capital asset maintenance.

Finally as reported on page 267, by January 2015 the ministry had not included estimated life cycle costs in its long-term capital asset plan for the provincial park system. It expects a function in the new enterprise asset management system will have the ability to capture determined life cycle costs for all capital assets. That concludes my presentation.

The Chair: — Thank you, Ms. Volk. Ms. Gallagher, if you'd like to make some comments.

Ms. Gallagher: — Thank you. So I would like to report on the progress that we have been making around our provincial parks' capital asset planning. The ministry has made significant progress in developing an overall management system for stewardship of our parks' capital assets. At the core of this system will be a data repository and decision tool in the format of a data management software product. And so we have, actually initially we have now procured the software product. That was finalized in December 2014 and implementation is focusing on a phased approach with a projected park system-wide go-live date later this month.

Ongoing infrastructure assessments will be required to validate the initial set of asset information and to assure the asset information remains current.

The ministry is also enhancing future trend and market analysis for the provincial park system. Occupancy preferences continue to drive capital planning and will ensure that the high demand we have for quality park amenities will be met.

In the last few years, the ministry has conducted annual provincial park camper surveys aimed at identifying visitor satisfaction with our park amenities, as well as their desired essential features of camping destinations. The survey is quite extensive and information gathered is used to identify program infrastructure improvements, in addition to the work that we're doing around capital asset management. So thank you.

The Chair: — Thank you, Ms. Gallagher. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well thanks again for this work. They're important recommendations. And I mean, our provincial parks are such a fabulous part of Saskatchewan and I think, you know, many of us have certainly grown up with utilization of those parks. And I know people like Ms. Emma Graney from the *Leader-Post*, who's sitting in this room, enjoyed a few this summer, and so she might have some perspective on this as well.

But it is important to have a plan in place and an inventory of the state of affairs for the assets, and as well an understanding of what's valued by park patrons and those that certainly utilize the parks itself. So this is really important work and I look forward to its implementation.

Will this be a public document once it's . . . I think there's a statement around going live in September here of this year. Will that be something accessible to the public?

Ms. Gallagher: — We wouldn't intend to make it . . . It would be very technical about, you know, how old something is, what state of condition it is in. But certainly if there was an interest, that information could be available.

Mr. Wotherspoon: — Okay. Thank you. That's important.

I have a more specific question about one of the provincial parks. And it relates to, I guess, when there's damage that occurs then and how that then jumps into being a priority for the ministry. And I'm sure you're aware that the marina at Rowan's Ravine was, basically through ice damage, was made inoperable for a large extent of what's been available there. And it seems to be a lack of clarity on the ground out in that area as to what the plan is of government to rectify that marina.

This happened this last spring and it isn't yet resolved. There were certainly actions to make sure that the boat launch was working, and that's important. And I just would like to get a bit of a status update. I have many people that connect with me on this matter, and I know they'd be pleased to hear kind of where, you know, what sort of actions and what sort of timeline will be in place to fix this marina.

Ms. Gallagher: — Thank you. So as you can imagine, there's a lot of work to do to assess the damage and work through to what is a good resolution. We try to keep flexible in our world in Parks. We are often having to meet unexpected natural disasters or crisises so we are able to accommodate that. I will turn it over to Byron because he is the lead on actually managing that file.

Mr. Davis: — Yes, thank you. Just to update, I guess, you know because the damage occurred in the, I guess, late winter, early spring with heavy ice damage and wind associated, there was severe damage to the piling system and so on in the marina. The ministry did initiate a PDAP [provincial disaster assistance program] claim for that particular incident, and there has been quite a process of analysis of the damage and looking at options to rebuild. And we can say that we have just recently received the PDAP response which we're analyzing now and looking at options going forward to re-establish the marina.

Mr. Wotherspoon: — Yes, basically the piles that were in place were knocked over and bent over and the dock system then inoperable. The docks though probably were getting towards their end of their lifespan at that point as well. So what are the options that you're looking at?

Mr. Davis: — Well included in the options could be re-establishing using the same piling system, which is somewhat difficult to re-establish given the dewatering of the marina and that type of thing. There are other options for piling systems that, now that we have discussed the issue with PDAP, we'll be exploring. But you know, the intent is to re-establish the marina as soon as feasible and with the best possible solution.

Mr. Wotherspoon: — Thank you very much. I appreciate as well the efforts of the survey with park patrons to have an understanding of what assets are valued and what potential developments would add great value to the experience within the park. So I encourage you in that work. I'm wondering if you can share, if you have recent data on that front, do you have data coming in to you that also states the . . . that identifies road conditions or highway conditions as a challenge for park patrons in certain parks. And if so, could you identify some of those parks that have been identified with having very difficult highway conditions to connect to them?

Ms. Gallagher: — And certainly that is a question that we do ask in our survey. So I'll turn it over to Byron as well because that is also in his branch's purview. But we do work on that continually, and we work in collaboration with Highways to try and address the problems. And perhaps Byron can share with you some of the current work that we're doing.

Mr. Davis: — Yes. And you know, park roads and highways approaching parks are obviously a large concern to the public and to our ministry. We work in collaboration with the Ministry of Highways to address those hard-surface roadway issues within the parks.

Most recently, we've done some substantial upgrading at Duck Mountain Provincial Park. More are planned for this fall at Cypress Hills Interprovincial Park. And we do maintain a roadway inventory for in-park roads that we are constantly updating, things change with the condition of the roads, based on weather and so on. And we are making headway in that regard, but it's definitely an important issue.

Mr. Wotherspoon: — Thanks for that information. Have you had identified with you the state of affairs out to connect with Rowan's Ravine Provincial Park?

Mr. Davis: — Yes. Well I think we understand, you know, obviously that Highways has been working on those access roads. They're developing, you know, a strategy for the longer term, for the access to Rowan's Ravine Provincial Park. We have done some upgrading within the park as well. But I think that work is ongoing and the plans will be defined in the future.

Mr. Wotherspoon: — Okay. Well I just would urge, you know, certainly urge listening to patrons on that front, on parks

all across the province. And you know, I know first-hand the experience that connects to Rowan's Ravine. It's pretty disastrous conditions, whether utilizing 322 or Highway 220, and certainly does connect to a park that's pretty vital to the experience of many. And I know just through my sort of what's been coming to me by way of information, there's quite a few folks that were less than happy campers by the time they arrived at the park. I'm sure once they got to the park, the experience was good. So anyways, just your continued attention on that matter.

[11:45]

The Chair: — Are there any further questions on this chapter? Mr. Michelson.

Mr. Michelson: — Just one comment. You say you work with the Ministry of Highways. Do you also work with the municipalities that are around specific parks as well, and to what extent?

Mr. Davis: — Well typically the highways, the hard-surfaced highways approaching parks are the main, I guess, concern from a parks perspective. We have worked with municipalities regarding, you know, the ongoing maintenance of some park roads where we have mutual interest.

But typically, with Ministry of Highways for hard-surface roads in particular, we try and coordinate work with their planned work and try and achieve the best feasibility for project and, you know, upgrade roads as the highest priorities, priority areas, and highest traffic areas, and so on. So we work closely with the Ministry of Highways, both with our own capital funding and with an allotment through Highways for park-related roadwork.

Mr. Michelson: — Yes. I would realize that highways would be, I would suppose, in the high 90 per cent of the approaching structure for parks. But on some level, I imagine there's a certain amount of municipal roads that would also need to be negotiated with, with certain municipalities.

Mr. Davis: — Yes. There is some coordination of efforts there, particularly at the park level.

Mr. Michelson: — Yes. Thank you.

The Chair: — Mr. Marchuk.

Mr. Marchuk: — Yes, thanks. Could you just elaborate a little bit on the criteria for projecting future park use? Obviously highways might be one of them, but what might be some other criteria that you would use to establish future use?

Ms. Gallagher: — So you're talking about numbers of visitors to the parks?

Mr. Marchuk: — Yes. That's what I'm assuming you're meaning by projected future use levels for key assets.

Ms. Gallagher: — So we do our analysis on what we see as usage in parks, and trends. With the park survey work, we do ask questions about what are preferences and what people are . . . expectations and what their interest would be going into the future. We also do work with looking at trends nationally. We may look at what's happening with recreational vehicle sales. We combine all of that type of information and use that to project where we may see increases.

For us right now, we are in an enviable position in Canada because we're one of the systems that is growing. There are very few park systems that have such a high demand. And so we're in a very good position where our growth is continuing on an annual basis.

Mr. Marchuk: — Thanks. Yes, good.

The Chair: — Are there any further questions on this chapter? Seeing none, as there's no new recommendations, could I have a motion to conclude considerations?

Mr. Doke: — I so move, Madam Chair.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2015 Provincial Auditor report volume 1, chapter 24, this committee conclude considerations. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you so much, Ms. Gallagher, and to your officials here today. Do you want to make any final comments?

Ms. Gallagher: — No, just to thank the Provincial Auditor for their work. We very much value their input and their assistance in ensuring that we provide quality services to the people of Saskatchewan. So thank you. And thank you to all of the members of the committee.

The Chair: — Thank you very much. This committee will stand adjourned until . . . [inaudible interjection] . . . Recessed. Recessed. We're not adjourning today until . . . We've got more work ahead of us. The committee will stand recessed until 1 o'clock today.

[The committee recessed from 11:49 until 13:02.]

The Chair: — Good afternoon everyone. Welcome back to Public Accounts. This afternoon we have a few agenda items in front of us. We will be dealing with Health, well completely the Ministry of Health; and Regina Qu'Appelle Health Region, Heartland Health Region, and the Prince Albert Parkland Health Region as well.

We will have a little jump in the order though if it's okay with the committee. We will deal with Health and then Prince Albert Parkland Regional Health Authority to allow them to be able to get on the road sooner than later, if that's all right.

Health

The Chair: — Welcome to the deputy minister of the Ministry of Health, Mr. Max Hendricks. You will have an opportunity to introduce your officials here shortly, but I will pass it off to the Provincial Auditor for her remarks on the next couple of

chapters before us.

Ms. Ferguson: — Thank you very much, Madam Chair, Deputy Chair, members, and officials. I'm just going to take a moment and introduce who I have with me this afternoon. On my left is Mr. Bashar Ahmad. Bashar's a deputy with our office and leads our Health division. Behind him is Ms. Lowe and Ms. Regan Sommerfeld. Both of them have been involved in the work that's before you this afternoon, and in addition Ms. Lowe is our liaison with this committee. So this afternoon she's doing double duty.

So before we start our presentations I just want to pause and thank the deputy minister, the staff, also all of the staff from the various regional health authorities for the co-operation that we received during the course of the work that's before this committee.

We will be presenting each chapter in the order that's presented other than the shift with respect to P.A. [Prince Albert] Health Region, but we will present one chapter at a time and then pause after each chapter. So other than the exception that was raised we'll be following the ordering of the agenda.

So I'm going to start with chapter 11 of our 2014 report volume 2, and that begins on page 75 of the report. And that chapter describes the results of our annual audits, 2014 audits, of the ministry and five of its agencies with March year-ends. At the time of this report we had not yet finished our audit of the Impaired Driver Treatment Centre because the centre had not finalized its financial statements. You'll find that this chapter does not contain any new recommendations for the committee's deliberations.

We note that the 2014 financial statements of the five agencies are reliable; they and the ministry complied with authorities governing their activities. And we also report that each agency and the ministry had, other than the three items that are reported, effective controls to safeguard public resources. We are pleased to say that the ministry has implemented five of our past recommendations. However at March 2014, it did not have a capital assets plan. Management indicated that the ministry expects to complete a capital asset plan by June of 2016.

Lack of a capital asset plan for the health sector, which has assets of over 1.4 billion, increases the risk that health care system may not have the capital assets it needs to deliver the programs and services, or that idle assets could be perhaps used at a different location or in some different capacity.

The other two recommendations, which are on page 78, related to the ministry's use of generally accepted accounting principles to account for shared-ownership agreements and funding for debt repayments.

In January 2014 your committee recommended that the ministry have its officials examine the issue and discuss further with our office these matters. Those discussions continue, and we expect to provide your committee with an update on the results of those deliberations in our next report. So at this point in time, we'll pause for your committee's deliberations and discussions.

The Chair: — Thank you, Ms. Ferguson. Mr. Hendricks, would you like to take a moment to introduce your officials and make some comments on this particular chapter?

Mr. Hendricks: — Yes. Thank you, Madam Chair, and good afternoon. On behalf of the Ministry of Health, thank you for the opportunity to be here today to discuss the 2014-15 Provincial Auditor's reports.

I have several staff with the ministry here but also outside the ministry from our RHAs [regional health authority] to help answer questions as necessary today. So maybe if I could briefly introduce, I think, most of them. Mark Wyatt, behind my left shoulder, is an assistant deputy minister. Also behind my left shoulder is Tracey Smith. Directly behind me is Kimberly Kratzig, assistant deputy minister; and to her right is Karen Lautsch who is also an assistant deputy minister.

We have here with us today Brenda Russell who is the executive director of our financial services branch. And seated to my right is Cindy Fedak, the manager of revenue and audit with the ministry and our internal auditor. We have Margaret Baker who is the executive director of primary health services, and Caroline Beck who's actually with us from the Johnson-Shoyama school. She's a graduate student who is interning under me this year.

From the regions, we have Greg Cummings, the CEO [chief executive officer] of the Heartland Health Region; Cecile Hunt, the CEO from Prince Albert Parkland Region. And with her is Linda Sims, the director of home care. We also have Sharon Garratt, the vice-president of integrated health services; and John Ash, the acting executive director of patient flow, pharmacy, and respiratory services from the Regina Qu'Appelle Health Region.

Madam Chairperson, the Provincial Auditor plays a vital role in ensuring that government remains effective, open, and accountable. At the Ministry of Health, we firmly believe in these same principles. They guide not only our strategic direction but our day-to-day operations of front-line care. The Ministry of Health and the regional health authorities are committed to the responsible, efficient, and effective management and delivery of health care. Knowing that the Provincial Auditor also shares these goals, we welcome this report and appreciate the effort and detail that was put into this review.

Progress has been made on a number of the auditor's recommendations and work continues in many areas, both at the ministry level and with our partners on specific areas of concern. Our ultimate goal is to strengthen and improve health care services for all Saskatchewan residents. And with that, we'd be pleased to take your questions. Thanks.

The Chair: — Thank you, Mr. Hendricks. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well thanks so much. Thanks to the auditor for their work and the recommendations, and thank you as well to the Ministry of Health for their work to respond to many of these recommendations, quite a few which have now been addressed fully and have been implemented, which is really good to see.

I guess just on the capital asset plan, these recommendations go back of course quite a few years, and I know it's certainly, you know, challenging and complex to gather the information and develop that plan. But could you speak maybe specifically to what some of the pressures have been to develop that capital plan and some of the actions and timelines for those actions that we'll see in the next few months?

Mr. Hendricks: — Certainly. The Ministry of Health, to say that we don't have a capital plan, we haven't actually formally published a capital asset plan. But as you're well aware, the ministry for several years now, beginning in I believe 2007, has undertaken VFA [Vanderweil Facility Assessors] studies of our capital assets in the health care system to really get a very detailed and in-depth understanding of the condition of our facilities, where our risks lie, and what our capital requirements are.

As you can imagine, with over $5 billion of capital in the health sector, it's an extremely complex undertaking to manage all of these facilities and make sure that maintenance is being done, that sort of thing, but also, you know, shifting our discussion to demographics and population growth, where the needs are, you know, with a shift to urban centres, increasing needs there. So we actually do a lot of that planning within the ministry. We do identify our capital priorities. One of the challenges with developing, obviously, a capital asset plan is that we can have a plan published and state our priorities, but in a fiscally challenging time like this, you know, it's often difficult to follow through with that plan based on budgets and such.

So I think that, you know, obviously our goal is to have a plan. We've said we're going to do that by the end of 2016, and we will try and have that done on time so that people have a better idea of what the capital priorities of the ministry are.

Mr. Wotherspoon: — Thanks for that answer. As far as the recommendations around proper accounting of assets and proper financial accounting, I know that the description from the ministry, as far as actions right now, is that there's going to be ongoing discussions with, I think it says Finance and with the auditor's office. I guess maybe I'll turn it over to the auditor and then maybe for subsequent response from the ministry.

But is there progress on this front to have an adequate resolution and make sure that the Ministry of Health is following proper accounting standards?

Ms. Ferguson: — There has been ongoing discussions in this matter, you know. And I actually think that we'll be able to, this next report that comes out the door, I think we'll be able to have them resolved by that point in time as to where things are at. So I'm optimistic, you know. I can't see my colleague's face down the table. I'm hoping he's smiling, that they're optimistic too that we'll get this resolved and see our way through these two recommendations.

These are the same recommendations that are in a number of other chapters too. So if you as a committee feel like you've seen them before, you have. They're just the same recommendations for different agencies.

Mr. Wotherspoon: — Thank you for that. Would you care to respond? I mean, I appreciate, you know, it seems that this is going to be resolved, and we would expect as much. And we appreciate, you know, the engagement of all to make that happen. But is there any . . .

Mr. Hendricks: — I would agree with the Provincial Auditor's comments that the work is ongoing. You know, these have been, I guess, long-standing recommendations that we've talked about in this committee before. And so I think too they're partially addressed by the movement to summary financial statements. And I think the comptroller and the Provincial Auditor's are the most appropriate offices to address those.

Mr. Wotherspoon: — Are the RHAs engaged in this discussion then right now as well?

Mr. Hendricks: — Not directly engaged. You know, they're aware of the issue, but they haven't been directly engaged in the discussions between the auditor and the comptroller's office.

Mr. Wotherspoon: — Have they noted challenges with the current accounting treatment that's being applied, the RHAs?

Mr. Hendricks: — Not to my knowledge, no.

The Chair: — I have a question, if the committee doesn't mind. I'm just wondering with respect to the VFA reports . . . So obviously last year you released the one, I think, that took place in the summer of 2013, if I'm correct. So the VFA information that we got last summer, the $2.2 billion was from, I think, the summer before. But can you tell us a little bit about how often you embark upon the VFA reports and how you keep them up to date?

Mr. Hendricks: — Yes, I actually just want to correct a previous statement that they're not aware. They are aware. They received qualified statements so, yes, they're aware of the issue but not of the discussion. So just to clarify what I said.

The VFA study is actually a living thing. What we actually do is from VFA we purchase software. That software is to be continually updated by health regions. So as improvements are made to health care facilities, they're supposed to log that information in the database so that at any given time we have a picture of the state of our health capital. Just recently we renewed the licence for that. So it's an ongoing project, if you will.

[13:15]

The Chair: — So last summer then, if it's an ongoing, that ever-changing, ever . . . the dynamic that happens with health care infrastructure, last summer it was $2.2 billion. Do you know where it's at right now?

Mr. Hendricks: — No. Because regions actually individually enter their own information, there's a collation that has to take place in order to produce the reports like you saw last summer. You know, and I'm not sure, we haven't really discussed when we plan to release an updated state of the union, if you will.

The Chair: — So you don't have any plan on . . . So would that fit into the capital plan, though, like the whole . . .

Mr. Hendricks: — Yes. That fits into the capital plan, yes.

The Chair: — Yes. Okay. And just with respect to the capital plan, I know, having been the health critic and have had conversations about this in the past, I know one of your key actions in '09-10, it was develop a 10-year capital plan back in 2009-10. So I know you spoke a little bit about the challenges, but this kind of time frame . . . so June of 2016, did you expect in 2009-10 that it would take this long to develop a capital plan?

Mr. Hendricks: — Well I didn't have the capital file in 2009-10, so I didn't have a lot of opinions on it. But I think that when you do a capital plan — and the education sector has probably a more robust capital plan than we do — there are several factors that come into play. And you know, I've talked about a few of them: a lot of the facilities that have been identified in the VFA study as being deficient and such that we would want to consider renewal, renovation, or replacement.

You know, they're pretty big projects and, more so than maybe a school or something like that, requires significant financial commitment by the province. So we have had an aggressive capital campaign in this province. As you know, over the last five and six years we have some pretty big projects up and going right now: children's hospital; SHNB [Saskatchewan Hospital North Battleford] is well on its way; Swift Current. So there's a lot of stuff happening. We're renewing our facilities. But it's a big challenge, you know.

I can easily identify, you know, probably what some of the biggest capital priorities are from the VFA study — and I think anybody can — and a good understanding from our demographics what the capital priorities are. It's just that we haven't formally articulated them in a plan, and we've committed to do that.

But in answer to your question, would I have expected it to take this long? You know, I think due to the fact that the VFA study was done in 2007 and updated in 2013, and a number of the capital investments that have been made . . . We do have a plan. It's just not formalized.

The Chair: — But you expect it to be formalized for June 2016?

Mr. Hendricks: — That's the expectation.

The Chair: — Okay. With respect to, obviously someone . . . We talked about some of the major capital builds that have to happen, but in that is also the maintenance of existing facilities. I know in this last budget it was 28 million that was allotted for maintenance. How does that all tie in to the capital plan that you're currently working on for June 2016?

Mr. Hendricks: — So it does factor in. Yes, you're almost bang on — $27.8 million in this fiscal year. So every year we have a budget that we allocate towards what we consider from the VFA study to be our highest priority needs. Like these are kind of those critical infrastructure things that we have to do, the life, safety, and emergency things. We always hold back a contingency for unforeseen capital issues that do arise.

So it is a big part of what we do. I think that it's well acknowledged that with, you know, $5 billion of infrastructure, could we do more? Yes, we could always do more. But when we are replacing facilities like the 13 long-term care facilities, SHNB, those actually change the VFA scores because right now SHNB would be kind of at the bottom end of our VFA score. And when that facility is renewed, you know, it's at 100 per cent. It's good to go. And so as we renew, we're also updating our VFA score. So it's a combination of both and they have to work together.

The Chair: — Just one more question. Sorry. Just wondering then, so obviously VFA scores tell you the state of infrastructure but don't necessarily tell you . . . I mean, we pick priorities, or governments pick priorities. What would be . . . Obviously the North Battleford hospital is a priority; building a children's hospital. Could you identify some of those priorities that you see coming out of the capital plan next spring?

Mr. Hendricks: — Yes. A couple of them or several of them have actually been announced by government and are in the planning stages. So long-term care for La Ronge, there's an issue about capacity up there. We do have, you know, some challenges in our urban areas with long-term care capacity just for the reasons I have said. P.A. Parkland, you know, some planning has begun on that, Weyburn hospital. So there have been . . . Several projects have been announced and planning is under way.

Now the ability to actually proceed with those projects depends on the availability of resources to actually carry forward.

The Chair: — Okay. So you've mentioned the Weyburn hospital, La Ronge long-term care. I'm just curious as a Saskatoon . . . someone who represents Saskatoon, I'm curious about where RUH [Royal University Hospital] falls in that mix.

Mr. Hendricks: — RUH, I think from a maintenance perspective, is one of the ministry's highest priorities because it is kind of a mission-critical facility. So there are some things that are happening at RUH in conjunction with the children's hospital that some folks don't realize. The emergency room, as you know, will be part of the new children's hospital. Also some of the work in terms of generation, heat, and cooling, that sort of thing, there have been issues with RUH, will be dealt with as part of the children's hospital build. So we're slowly trying to get at that.

One of the things that we have to consider in the coming years is how we redevelop that facility. Obviously there'll be space vacated by the movement of the pediatrics and maternity to children's hospital, and the emergency as well. A lot of things to consider, but definitely it would be one of the highest on our priority list.

The Chair: — Okay. Thank you. Just one more question. So the VFAs, the collated reports that have been run in recent years, started in 2007 and then you ran sort of the more complete picture in 2013. Has there been a complete picture run at any other time? So obviously you said it's a living database, but I'm just curious about that more fulsome picture of the number.

Mr. Hendricks: — When we first purchased the licence in 2007, as I mentioned, you know, there was an expectation that regions populate the database and that sort of thing. For a while there that wasn't happening. And actually we let our . . . We decided not to do it for one or two years. We renewed our licence, I think it was in 2011-12, just before I took over the file. The VFA study was then, you know, obviously we had to send the assessors out into the field to redo everything to take stock of where it was. So 2013 was the last, I believe, update that we've actually had of the system, system wide.

The Chair: — Thank you very much. Sorry. Thank you for indulging me from the Chair. Are there any other questions on this particular chapter? No? Seeing no further questions on this particular chapter, we don't have any new recommendations with which we need to deal. Could I have a motion to conclude consideration.

Mr. Doke: — So moved, Madam Chair.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 11, that this committee conclude consideration. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on the next chapter, I shall pass it off to Ms. Ferguson again.

Ms. Ferguson: — Mr. Ahmad will make this presentation.

Mr. Ahmad: — Thank you, and good afternoon, Madam Chair, members of the committee, officials. Chapter 23 of our 2015 report volume 1 begins on page 257. The chapter reports the result of our follow-up work on the ministry's progress toward addressing the 12 recommendations we made initially in 2012. Those recommendations related to the ministry's processes for preventing diabetes-related health complications. Diabetes is one of many chronic diseases. Your committee considered and agreed with those recommendations back in September 2014.

By February 2015 the ministry had implemented four recommendations, and it was working toward implementing the remaining eight. I will focus my comment on the recommendations not fully implemented. Three of those recommendations, on page 259 and 261, relate to establishing processes to monitor that people with diabetes receive and have access to appropriate services and to accumulate provincial spending information to assess the reasonableness of resource allocations for prevention programs and serving people with diabetes.

At February 2015 the ministry was in the early stages of collecting and analyzing data related to services provided to people with chronic diseases, including diabetes, to assess the alignment of physician-provided care with best practices. For example, while it had successfully enrolled 600 physicians to integrate the chronic disease management quality improvement program into their practices, fewer than half of them were actively using the program tools and submitting data to the ministry. It was also working with RHAs to provide necessary services to people with diabetes, but by February 2015 it has not started to monitor what services were available in each of those 12 RHAs.

The ministry collected some information on direct costs attributed to diabetes, but did not have a process to accumulate costs including, for example, hospitalization, the renal program, RHA staffing and programing. Management indicated that the ministry expected to start assessing resource allocations on provincially delivered programs in the near future.

Two recommendations on pages 261 and 262 are related to ensuring diabetes-related resources on a regional basis are effectively deployed and that the related plans and programs of regional health authorities align with the ministry's chronic disease management strategies.

By February 2015, RHAs gave the ministry their primary health care plan including some actions related to chronic disease management. Management indicated that the ministry's primary health service consultants reviewed those plans and provided feedback to the RHAs. Unfortunately we were unable to determine if those consultants confirmed the RHAs' actions aligned with its strategies because they did not document their review or feedback to RHAs. Also because the ministry had not analyzed which services were available in the RHAs, it did not know whether RHAs' services aligned with the ministry's strategies.

Two other recommendations related to collecting and analyzing information to assess whether physicians, care providers, and, in turn, regional health authorities deliver effective programs to manage diabetes and help prevent diabetes-related complications. The ministry was working with eHealth to develop solution to gather this information electronically.

For the final recommendation on page 264, we report that the ministry has reported its five-year targets in its 2013-14 annual plan. It had not yet reported its progress towards meeting those targets specifically related to people with diabetes and diabetes-related complications. And that concludes my overview.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to make some comments on that chapter?

Mr. Hendricks: — Sure. So maybe I'll just go through the recommendations fairly quickly and kind of give you a status update.

So the auditor's recommendation on chapter 23, page 258, "We recommend that the Ministry of Health implement an actionable work plan relating to chronic disease management including diabetes and prevention of diabetes-related health complications and provide guidance for regional health authorities." The Provincial Auditor has acknowledged that we've implemented that.

On page 258, "We recommend that the Ministry of Health set goals, objectives, performance indicators and targets to manage diabetes and prevent diabetes-related health complications." The auditor has acknowledged that we've implemented that.

On page 259, "We recommend that the Ministry of Health

establish processes to monitor that people with diabetes receive appropriate services to reduce the risk of developing diabetes-related health complications." The ministry has implemented processes to track both access to and appropriateness of care related to diabetes.

The chronic disease management quality improvement program was implemented in 2013. The program supplies health care providers with the necessary tools to provide care based on clinical best practices for managing diabetes. The participation and utilization of this program is also being tracked. The ministry has established a goal that by 2020, 80 per cent of patients will be receiving care according to the best practice guidelines for managing diabetes. The chronic disease management quality improvement program performance indicators track adherence to best practices for diabetes and complications on an individual physician-patient level and can be grouped by practice.

[13:30]

In addition, the standardized performance indicator data related to best practices for diabetes and its complications is now being collected in the electronic medical record or the electronic health record . . . [inaudible] . . . is stored in a data repository. So we have a good idea of those who are collecting this information and what the status is.

With respect to the recommendation on page 259, "We recommend that the Ministry of Health establish processes to monitor that people with diabetes have access to appropriate services in the province," the ministry has implemented processes to track both access to and appropriateness of care related to diabetes. In 2015-16 the ministry will survey the regions to identify the programs and services available in each region for persons living with diabetes. The ministry will then access the equity of programs and services across all regions. As well, regions monitor and report on improvements in patient access to primary health care teams.

The fifth recommendation on page 260, "We recommend that the Ministry of Health work with the Saskatchewan Medical Association to establish a method for assessing physician activities in monitoring people with diabetes." We have implemented that recommendation.

The sixth recommendation:

> We recommended that the Ministry of Health implement processes to accumulate, analyze and monitor provincial spending information on people with diabetes, and on diabetes-related complication prevention programs to assess the reasonableness of its resource allocations.

The ministry does currently collect information on direct care costs such us medications, the insulin pump program, that sort of thing. Other costs can be estimated such as hospitalization, the renal program, those incurred by regional health authorities on staffing and programming.

We have committed to assess the resource allocation on provincially delivered programs, on these chronic disease programs, by 2015-16. However building the systems and tracking all of this information, just in terms of the way our finance system is currently structured with regions, is kind of complex. So it takes a little bit of work.

Seventh recommendation on page 261:

> We recommend that the Ministry of Health work with regional health authorities to ensure resources on a regional basis are effectively deployed to manage diabetes and diabetes-related health complications.

The ministry has established objectives and targets related to chronic disease management, including diabetes, through the chronic disease management quality improvement program. Performance indicator data is being collected to monitor whether patients are receiving care consistent with best practice. In addition, the ministry is working to identify and address gaps in care for patients living with chronic diseases.

In 2015-16, the ministry will survey regions to identify programs and services available in each region for persons living with diabetes. The ministry will then assess the equity of access to programs and services across all regions. So we view this as being in progress and we've set a target date of March 31, 2016.

On the eighth recommendation:

> We recommend that the Ministry of Health review regional health authorities' Primary Health Care plans and programs to ensure that they contain appropriate actions and align with the Ministry's strategies relating to chronic disease management including diabetes management and prevention of diabetes-related complications.

All regions provided primary health care plans for 2014-15 outlining actions to increase access to collaborative team-based care. Ministry feedback to the regions was provided as part of the regularly scheduled meetings. As well, outcomes in terms of decreased hospitalizations for chronic conditions including diabetes and targets increased access . . . such as increased access and provision of care consistent with best practices for chronic conditions are being monitored.

The ministry has committed to review and provide formal written feedback. I think that was the issue, is that we didn't provide formal written feedback to the regions on those plans. We'll do that in 2015-16. In addition, as part of the region's plan for progressing primary health care, regions are to include information on chronic disease management, including diabetes programming and physician participation in the chronic disease management quality improvement program. So we'll be done that by '15-16.

The ninth one, on page 262:

> We recommend that the Ministry of Health implement processes to gather sufficient information relating to people with diabetes and diabetes-related health complications to ensure they are receiving care consistent with provincial standards.

This has been implemented.

The 10th recommendation, on page 263:

> We recommend that the Ministry of Health collect and analyze information to assess whether services delivered by physicians and care providers are effective and if they provide needed services to people with diabetes to prevent diabetes-related health complications.

Again, under the chronic disease management QIP [quality improvement program] program, data related to diabetes and its complications is collected through an electronic medical record and the electronic health record viewer, and enables the ministry to assess whether the services provided in relation to managing diabetes are effective.

In addition, performance indicators related to complications — i.e. blood pressure, smoking status, and screening for nephropathy or ophthamological conditions, foot issues, and depression — are also collected. As well, the ministry will be seeking permission from the health information privacy commissioner in ’15-16 to analyze the CDM-QIP [chronic disease management quality improvement program] data to monitor and assess the effectiveness of services provided by health care providers and to report that information on a regional and provincial level.

The 11th recommendation:

> We recommend that the Ministry of Health collect and analyze information to assess the effectiveness of regional health authorities’ programs to manage diabetes and the prevention of diabetes-related complications.

The ministry continues to work with eHealth to develop a health system analytic service to provide advanced data analytics and health intelligence reporting. The foundation, i.e. the governance . . . [inaudible] . . . the roles and responsibilities, policy, legislative supports, and standard work processes will support appropriate care and effective system management in the regions. The health system analytic service is expected to be developed in 2016-17.

In addition, the ministry will be seeking permission from the health information privacy commissioner along the lines of the last information to analyze the CDM-QIP data and to monitor and assess effectiveness and report this information back at the regional and provincial level.

On page 264, the recommendation no. 12:

> We recommend that the Ministry of Health publicly report progress in implementing the strategies to manage chronic diseases separately identifying diabetes and prevention of diabetes-related health complications.

The ministry does report on progress towards strengthening primary health care and chronic disease management through the annual health system plan.

Hospital utilization for people with diabetes will be reported in the ’15-16 annual report. The ministry will seek permission from the health information Privacy Commissioner, again to release this information on a regional and provincial level. As well, the ministry is developing a diabetes logic model that will be shared with regions in ’15-16 that will provide an overarching framework and of expected outputs and outcomes and will enable regions in the province to have similar indicators on diabetes complications. The data collected will be reported in our ’16-17 report. So that concludes my rather lengthy comments.

The Chair: — Well lots of recommendations there. Thank you, Mr. Hendricks, for that. I’d like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well first certainly thank you to the auditor for the recommendations, but thank you for that report as well and the detail that you went into but at the same time being focused on each of the recommendations.

And I know you’d have folks working directly with you to help fill out some of the reporting that we received in advance as well. The template that speaks to some of the actions and timelines, that’s actually really helpful for us to sort of see where things are at before we come into . . . before we get to this table. So thanks for all the work. That’s a large body of work and it’s certainly very important.

Just when looking at the recommendations 4 and 7 and the survey that was referenced by the deputy minister, where’s the ministry at in conducting the survey with regions to identify the programs and services that are available in each region for persons living with disabilities?

Ms. Baker: — We’re just in the process of finalizing that survey now. It’ll be out, we hope, within the next month or two.

Mr. Hendricks: — Sorry. That’s Margaret Baker, executive director of primary health services.

Ms. Baker: — Sorry. I should’ve introduced myself.

Mr. Wotherspoon: — Thank you for that information, and certainly that’s important work. There’s a couple references to working with the Privacy Commissioner to ensure that data is being shared in an appropriate fashion relating, I think, to some of the electronic records that are important to implementation. Where’s that conversation at, or where’s that process at ensuring I guess the integrity of the privacy of patients and individuals but allowing as well, you know, meaningful action to address the recommendations?

Ms. Baker: — We met with the Privacy Commissioner and through . . . from the very beginning of this process to ensure that the data that we’re currently capturing, that’s being extracted from EMRs [electronic medical record] and put into the data repository, is compliant with privacy requirements.

The second piece that we will begin within the next couple of months is around how we can use the data that’s being captured now into a data repository. And the first stage of the privacy assessment was whether we could capture that information and share it back to the providers so that they could use that to be able to better manage their patients. The second part is more around the data that’s in the repository and use of that data in an aggregate de-identified way to be able to do system planning,

and we will be starting that within the next couple of months.

Mr. Wotherspoon: — Thanks for those answers.

The Chair: — Looking around . . . Mr. Doke.

Mr. Doke: — How many endocrinologists are there in the province? Any idea?

Mr. Hendricks: — So as of January 31st, 2015 there are seven registered endocrinologists in the province, three in Regina and four in Saskatoon. Additionally there are four general internal medicine physicians in Moose Jaw and Prince Albert with an interest in endocrinology and some specialized training in it who provide care to people with diabetes. Four additional internists in Saskatoon also provide diabetes care during pregnancy.

Two of the seven endocrinologists accept referrals for pediatric patients with diabetes, as does the internal medicine specialist in Moose Jaw. And one of the four endocrinologists in Saskatoon is a pediatric endocrinologist and he's the only one in the province currently, but we're looking at that in conjunction with the services that will be provided in the new children's hospital.

Mr. Doke: — I'm assuming then none of them travel out like to P.A. or to The Battlefords or Swift Current. There wouldn't be anybody going out. You'd have to go in to see the . . .

Mr. Hendricks: — I just want to ask Cecile. I'm not absolutely sure. Not for direct service care, but they do provide continuing education to physicians in those communities.

The Chair: — Are there any further questions? Just one that's popped up for me, just your comment about the pediatric endocrinologist and having one in the province right now and tying the recruitment of another one to the children's hospital which will be open in 2019. I know that number has changed over the years. How has sort of that shifting landscape and now landing on 2019 impacted the recruitment of specialists?

Mr. Hendricks: — Well so this is how fast the ministry moved since I last gave an update. We actually recruited a second one, and he started August 17th.

It does impact, obviously. One of our challenges with the children's hospital is that there are a lot of subspecialists, that we're contemplating adding additional resources in our subspecialties, pediatric as well as general pediatrics as well. And so kind of as opportunities have arisen to recruit those subspecialists to Saskatoon, we take advantage of those when they come.

So you know, I think certainly the children's hospital and some of the excitement around that has helped improve Saskatoon's visibility in terms of a centre that people want to come to to practise pediatrics. But as I said, you know, it's definitely based on when we have opportunity and also if we have the available resources. And the college has laid out a plan that we've looked at and we, you know, are working with them to try and recruit the adequate pediatric resources that the hospital will need.

[13:45]

The Chair: — Is the college's plan a public plan? I don't know if we've ever discussed it. I'm not familiar with that.

Mr. Hendricks: — Hopefully they discussed it publicly.

The Chair: — Okay. In terms of some of the subspecialists, can you tell us what some of those would be?

Mr. Hendricks: — Yes. So endocrinology is one. Just by nature of our population, there are high needs there. Respirology, surgical pediatrics, several of those areas we're looking at.

The Chair: — Okay. But in terms of the timeline, as I think sort of my original question was, that date has changed. How does that impact sort of the recruitment? Obviously I can see having a children's hospital being a bonus, but having a children's hospital in four years from now, does that impact recruiting at all?

Mr. Hendricks: — You know, I think the way I would look at is, the children's hospital will be a special place in the province for care of children, but the children's hospital is a building. And right now we're already, you know, thinking about the needs of our children in this province and so, as I said, we're recruiting as opportunities exist within our existing infrastructure. So the date hasn't really been a factor in that.

The Chair: — Okay. Thank you for that. Are there any . . . Oh, Mr. Wotherspoon.

Mr. Wotherspoon: — Maybe just touching on the . . . We certainly hear and note the prevalence of diabetes in northern Saskatchewan, and sometimes hear about pressures and challenges to access services and supports in the North.

Has there been any . . . I know you're surveying all regions across the province, but do you have any analysis, you know, at this time as it relates to the adequacy of services and supports for those with diabetes in the North?

Ms. Baker: — Well I would say we would get more information on that with our survey. The prevalence is higher, and incidence, in the North. As we work towards strengthening primary health care, we've worked to also increase access to team-based care in the North. We've also looked at using technology to increase access in remote areas. We have a pilot around remote presence technology that is linking remote communities in the North to access to specialist services, for example, pediatricians. And not endocrinologists just yet, but there is opportunities to look at that technology for all types of specialties.

Mr. Wotherspoon: — Thanks for the information, and thanks for the commitment to the work into the future as well. Certainly it's important to the entire province, but certainly for those in the North as well.

The Chair: — Mr. Norris.

Mr. Norris: — Yes, thanks very much. I just wanted to follow

up. I've had the opportunity to be present for the first University of Saskatchewan nursing grads to go through their graduation ceremony in La Ronge, and others in Ile-a-la-Crosse. We know the significance that RUH especially plays in liaising with the North. Could you highlight some of those connections, obviously technological connections, that are well under way both for skills training — I'm thinking about the College of Nursing — but also some of the other programs that connect Saskatoon and the health region into the North? Because I think it would be helpful to highlight some of the work that's under way.

Mr. Hendricks: — As you noted, we do now actually have . . . We are training nurses in Ile-a-la-Crosse, La Ronge, in Sunrise Health Region, in Prince Albert Parkland. We're training them across the province, not dissimilar to the distributive medical education model that we're using. As part of that, obviously the requirement's to have technology so that they can, you know, engage with their clinical leaders back home in Saskatoon, that sort of thing. So as part of setting up those programs, we have to establish those technology links.

But you know, I think more and more one of the things in this province, you know, and Margaret started talking about it, is having providers who are interested in practising in the North. And we found that in fact in the case of physicians, you know, the residency positions in La Ronge are oversubscribed. There is more interest in going there. And in P.A. too, a lot of interest in going up there and having that experience. But in terms of delivering service to the people, that's really good to have stable, you know, to have stable services up there and people interested in training there and just with the technology things that come along with it.

But in this province we still need to do a better job of utilizing Telehealth and some of the opportunities that exist to link, for example, people with diabetes to endocrinologists in Saskatoon and even into communities in La Ronge because La Ronge can be remote to another community further north. And so as a province we need to do a better job of utilizing it, and I think that as the technology gets better and, you know, physicians can actually have that engagement in their own offices without going to a specific Telehealth suite, it gets better. And then also there is some of the work that Dr. Ivar Mendez is doing in terms of providing care remotely. So a lot of exciting developments on that front.

Mr. Norris: — Thanks very much for the overview.

The Chair: — Are there any other questions on this particular chapter? Seeing none, as we have no new recommendations on this particular chapter, we just need a motion to conclude considerations.

Mr. Doke: — So moved, Madam Chair.

The Chair: — Mr. Doke has moved, thank you, that for the 2015 Provincial Auditor report volume 1, chapter 23 that this committee conclude considerations. Are there any comments or questions? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Prince Albert Parkland Regional Health Authority

The Chair: — Moving on now to Prince Albert Parkland Regional Health Authority. So we'll just have a quick . . . Oh we don't need a recess. There's Ms. Hunt. Mr. Ahmad.

Mr. Ahmad: — Thank you, Madam Chair. Chapter 36 of our 2014 report volume 2 begins on page 257. It reports the result of our audit of home care services by P.A. Parkland Regional Health Authority. Home care services are an integral component of our health care system as they enable individuals with health needs to live independently in their own homes. These services also relieve pressure on other parts of the health care system such as the need for acute care or long-term care. The Ministry of Health has established a home care policy manual that includes policies and guidelines that RHAs must follow for providing home care services.

Health authorities provide professional services such as nursing at no cost and charge fees for support services such as personal care and Meals on Wheels.

Figure 1 on page 259 lists the home care services available in P.A. Parkland. P.A. Parkland region has a population of over 81,000. About half of the region's residents live in P.A. and the remaining live in towns, rural municipalities, or First Nation communities.

Our objective was to assess the effectiveness of P.A. Parkland's processes to provide timely and appropriate home care services. We concluded that, except for the matters that are reflected in our recommendations, P.A. Parkland had effective processes to provide timely and appropriate home care services for the period from August 1st, 2013 to July 31st, 2014. We made 12 recommendations.

On page 261 we recommend the authority maintain policies and procedures relating to care planning for home care services that align with the ministry's 2013 policy manual. In 2010, the authority established numerous home care services and procedures; however, we did not find evidence the authority reviewed these policies and procedures to ensure they're aligned with the ministry's 2013 manual. We identified differences. For example, the authority did not have a policy for developing home care plans and a requirement to assess and revise those plans.

On page 262 we recommend the authority establish a process to identify home care services needs and trends in the region. The authority did not have a formal process to identify key changes, key changing needs and trends in the region and to address those changes. For example, although the authority discussed changing home care service needs, we saw no evidence of any changes to its home care services to respond to those changing needs.

On page 263 we recommend the authority develop a plan to provide consistent training to its staff delivering home care services across the region. Even though the authority made formal training available, it did not provide training consistently throughout the region. It did not have a formal plan to provide

consistent training to staff engaged in providing home care services.

On page 264 we recommend the authority follow its established policies and procedures and complete the needs assessments as required for home care services. The authority has established standard checklists and forms that staff are expected to complete when assessing new clients. However, 18 per cent of the files that we tested did not include checklists and another 24 per cent of the checklists were incomplete.

A client's home care plan outlines home care services to provide, indicates how often and an estimated time to complete them. We found that staff entered the information the authority collected on each client into a database system and assessors used the information in the database to prepare home care plans. However, the information in the database was not complete. As I noted earlier, staff did not always collect all of the information expected when completing their assessment of the client. This increased the risk that the home care plans may not be appropriate.

On page 265 we recommend the authority require supervisors to review and approve home care plans. For the home care plans that we examined, the supervisor did not always review or approve them to ensure they were appropriate.

Also on page 265 we recommend the authority prepare and approve work schedules consistent with home care plans. The authority used weekly schedules to help ensure clients receive the care set out in their home care plans. However, for 21 per cent of the files we tested, the home care services scheduled did not align with the care set out in the home care plan. For example, instead of a worker spending 15 minutes per day to attend to a client's anti-embolism stocking as set out in the home care plan, the worker was scheduled to provide this service three times a week.

On page 266 we recommend the authority implement a process to coordinate and communicate home care needs of clients with other services provided in the region and work with the ministry and other RHAs for coordination and communication of home care needs of its clients.

For 25 per cent of the files we tested, communication between service providers was inadequate. Management indicated that the transition from acute care to home care is often problematic as acute care departments do not always inform home care about the discharged patients, and the paper files received from those departments are not always complete. Effective communication and sharing of information between all departments is essential for delivery of home care.

Also on page 266 we recommend the authority regularly review home care client files as part of monitoring staff performance.

On page 267 we recommend the authority seek regular written feedback from current clients, including the timeliness and appropriateness of home care services.

Monitoring the services home care staff provide differs from monitoring services provided by staff working within facilities because home care staff primarily provide services within clients' homes. They often work independently and are not under direct supervision of management.

We found that other than annual performance reviews, the authority did not systematically review the work of the home care staff to confirm they provided the services expected. Also, we found that the authority's exit surveys of past clients focused on staff actions rather than the delivery of services. Not seeking the client feedback on service delivery increases the risk that the authority may not have accurate information to assess the quality of its services.

On page 268 we recommend the authority implement a process to track and analyze complaints related to home care services. While the authority's quality management department investigated and resolved complaints it received directly from clients, it did not collect and analyze complaints that home care staff received. Not tracking and analyzing all complaints increases the risk of missing potential systematic problems and not taking appropriate corrective action.

And finally, on page 268 we recommend the authority identify and collect key information to analyze the quality of its home care services. While the authority collects some information to track service delivery performance, it did not collect or analyze information on quality of its home services. Doing so would help to follow up on trends and recommend any improvement to its services. That concludes my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks.

Mr. Hendricks: — Okay. Maybe I'll start and then I'll ask Cecile to add any comments. I think this is a great example of a report where the auditor's recommendations help us to identify areas where we as a health system can improve. You know, the auditor did acknowledge that Prince Albert Parkland does have timely and appropriate home care services but actually these are appreciated recommendations and I think some are helped . . . You know, sometimes staff help the auditor identify issues and areas for improvement. So we welcome these.

I'll go through the recommendations quickly just giving you an update because there are some that the region has already implemented but the auditor hasn't been back to sort of verify that. But I'll let you know where things are at.

[14:00]

So on 261, "We recommend that Prince Albert Parkland Regional Health Authority maintain policies and procedures related to care planning for home-care services that align with the Ministry of Health's Home Care Policy Manual," the region has reviewed its policies and procedures related to care planning for home care services. Many policies were revised and/or new policies were created to meet this recommendation, and will be shared with staff in monthly staff meetings by March 31st, 2016. The policy for specialized assessments is still in progress but they do expect to have it completed by December 2015. So that one is still in progress.

On page 262, "We recommend that the Prince Albert Parkland Regional Health Authority establish a process to identify home-care service needs and trends in the region," the home

care management team has revised the referral source table used on intake to more accurately identify needs of people being referred. Data capturing of home care service needs and trends was presented in the Prince Albert Parkland home care report and presented to the board of directors in June 2015. Beginning in September 2015, the region's epidemiologist will assist home care program staff in trending information related to home care service needs. This information will support long-term planning and program development. We expect to have this recommendation fully implemented by December 2015.

On page 263: "We recommend that Prince Albert Parkland . . . develop a training plan to provide consistent training to its staff delivering home-care services across the region."

The region has implemented this recommendation. Regional home care orientation checklists have been developed for all new home care employees. Each home care site has its own site-specific orientation checklist that may vary due to geographical differences and different staff designations. Nurse educators have developed a checklist for both nurses and continuing care aids' orientation to ensure all aspects of orientation have been met. In addition, training from nurse educators is available on an as-needed basis. As well an online learning information management environment was rolled out in September 2015 which will enable managers to keep up to date on the training needs of employees.

Recommendation no. 4 on page 264, the region has developed an algorithm to determine the order of care — example given, example assessments, therapies, that sort of thing — as well as a checklist for the chart audits to ensure that needs assessments are being completed in full and that policies and procedures are being utilized consistently. In addition a nursing file audit will be completed by October 2015. That's under progress, in progress too.

Recommendation no. 5 on page 265, "We recommend that Prince Albert Parkland . . . require supervisors to review and approve home-care plans." The region has developed standard work for supervisors to review and implement programs or approve home care plans to match the service required. So we believe that this has been implemented.

Recommendation no. 6 on page 265, "We recommend that Prince Albert Parkland . . . prepare and approve work schedules consistent with home-care plans." The region will develop work schedules consistent with home care plans by September 30th, 2015.

No. 7 on page 266, "We recommend that Prince Albert Parkland Regional Health Authority implement a process to coordinate and communicate home-care needs of clients with other service providers in the region." The home care referral form has been revised to ensure that all information is being collected when patients are being discharged from acute care. As well an intake form has been created to collect further information for services. A rural intake nurse position has been hired to ensure services are clearly determined for clients. And so again we would see this as having been implemented by the region.

No. 8 on page 266, "We recommend that Prince Albert Parkland . . . work with the Ministry of Health and other regional health authorities for coordination and communication of home-care needs of its clients." The region's home care leadership now regularly attends home care . . . [inaudible] . . . provincial meetings as well as provincial stakeholders' advisory groups. Outcomes of the meetings will reflect policy changes at the local level. The regional director of home care and the director of patient care coordinator unit now meet regularly to resolve communication issues. As well the policy on transition and discharge of home care clients has been revised to include a work standard summary home care discharge plan, and work standards for transitions from agency to agency and program to program. So again the region feels that this recommendation has been implemented.

On no. 9 on page 266, "We recommend Prince Albert Parkland . . . regularly review home-care client files as part of monitoring staff performance." Chart audits will be implemented by October 2015.

No. 10 on page 267, "We recommend Prince Albert Parkland . . . seek regular, written feedback from current and past home-care clients, including information about the timeliness and appropriateness of home-care services." Surveys will be administered to the region to both current and previous home care clients, including Meals on Wheels in September 2015, and regular clients in October of 2015. So that's in progress.

And then on page 268, "We recommend Prince Albert Parkland . . . implement a process to track and analyze complaints related to home-care services." The process for complaints will be modelled after the region's current process for incident reporting. Data analysis will occur quarterly to identify trends and change policies and processes accordingly. This will be implemented by December of 2015.

And lastly on page 268, "We recommend that P.A. Parkland identify and collect key information to analyze the quality of home care services." The region has developed a process to identify and collect key information pertaining to the quality of its home care services. Data has been collected and presented to the Prince Albert Parkland regional home care report . . . Or sorry, the report has been presented to the board of directors in June 2015. In addition each data element on the visibility wall that is off target has a corrective action plan. So again the region also feels that they have implemented that recommendation. Cecile, did you have any other comments?

Ms. Hunt: — Well we certainly welcome the audit by the Provincial Auditor's staff. This gave us an opportunity to really have an in-depth look at the work that we do day in and day out in our home care program throughout the health authority. And it did provide us an opportunity to look at consistency of practice between some of our rural and the urban site, especially in the area of review of staff performance and ensuring consistency of the home care plans. Certainly it gave us an opportunity to look at our staffing complement and, as an example, we have implemented the intake nurse in our rural site which now . . . and it's based in Shellbrook. There was an urban intake nurse, and this gave us an opportunity to create some consistency and improve the care we deliver to all of our patients regardless of their home community.

We do recognize that we had been doing satisfaction surveys or assessing the quality of care, but usually only on discharge from home care programs. And so this, I think, gave us pause to consider that we needed to have more robust information provided to the leadership team as well as to the board of directors around ongoing service. So that's in the process of being implemented. So we do certainly thank the Provincial Auditor for their feedback.

We have provided some evidence of our implementation to the Ministry of Health, and when we have our next visit with the auditor's staff, we'll be able to complete that review.

The Chair: — Thank you, Ms. Hunt. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Well just thanks so much for this body of work, and certainly the efforts, you know, are really important. The activities that are supporting those through home care of course make a difference to so many in your region and certainly in others across the province. So thank you for the actions that have been taken to date and the other actions that will address some of the outstanding recommendations.

I have a question just around the number of clients or patients that are served in the region through home care, and if you have some numbers this year and then go back a few years.

Ms. Hunt: — I'll just get some information from Linda Sims, our regional director of home care.

So this year's current target is 3,955. So that's for the entire region.

Mr. Wotherspoon: — And then is that broken out as far as who's supported for Meals on Wheels alone or . . .

Ms. Hunt: — Yes, we would have that number. These are units of service or visits for nursing, would be about 40,000 for the home support. So that's through continuing care; that might be meal preparation, home services. Those services are approximately 65,000. Meals in this fiscal year or in the last fiscal year were approximately 30,000, and those Meals on Wheels are both urban and rural. There's different methods to deliver those home services, those Meals on Wheels, but that's the number.

Mr. Wotherspoon: — So 3,955 total clients served right now. Do you know how many are served, how many Meals on Wheels clients are served?

Ms. Hunt: — You know, I don't know if we've got it broken down. This is the total number of clients who get a variety of types of service, sometimes multiple times in a day. Meals on Wheels would be daily, but I'll just ask.

Mr. Wotherspoon: — Sure.

Ms. Hunt: — Linda indicates that approximately 500 individuals within the region have Meals on Wheels.

Mr. Wotherspoon: — And the Meals on Wheels, it's delivered . . . Can you explain how that program's delivered?

Ms. Hunt: — So when a client is assessed as needing that nutritional support, the Meals on Wheels are often, depending on the opportunity to deliver that service in that community, may be prepared, let's say in the rural community, at the local long-term care facility, as an example in Leask. And they would deliver it to those clients who might be served within the community of Leask or the surrounding areas.

In the community of Prince Albert, we use a community-based organization to prepare our Meals on Wheels and we have a team of volunteer drivers that delivers that.

Sometimes when they are quite . . . live in a remote area where it's not as easily delivered on an ongoing basis, we may prepare or purchase frozen products from those providers and then have them available in their freezers. That's not always, you know, perhaps the best solution, but it is a solution to ensure adequate nutrition.

Mr. Wotherspoon: — Well thanks for some of that information. And I always find some of these volunteers that get these meals out, you know, through the coldest days of winter and all year round are just some of the most remarkable people. I think of a gentleman in my own riding that's close to 90 years old that still is delivering with dedication every single day, those meals. And he's of course providing a little bit of care as you show up as well. So just thanks to all those that are involved in that program.

I'm just looking at the figure on page 259, tracking the number of home visits, and those numbers extend until 2013-14. And there's certainly a reduction in visits over that period of time that's illustrated in the diagram there, from close to 90,000 down to visits of, you know, sort of it looks like 67 or 68,000 visits. And I think you just shared a number maybe that would have been about 65,000. Is that the current year? I guess, what's happening with the number of visits in the region, and what trends are allowing for this reduction in visits, or what other circumstances are causing this reduction?

Ms. Hunt: — Certainly our home care program is attempting to keep individuals in their own homes. So yes, it is about that continuing care, that home support. But also there's been a mirror response to improved discharge planning, that nursing support around post-discharge in those first 14 days if they require it.

Really we have seen a significant shift from the rural communities to a more concentrated population shift to our urban areas. We are really attempting to ensure that post-surgical or the post-acute admission and transition back to independence has been a significant focus for us. And you would see there's been a steady increase in our nursing services. So it is also I think a reflection of a continued, really looking at what other supports do families have? How do we capitalize on their family resources as well as community support? But we do recognize that there has been a steady decline in our support. I'll just check with Linda if I've got the answer complete.

[14:15]

The other piece Linda says, the visits don't always indicate . . . We just capture the visit. But one visit might be 30 minutes.

The next visit might be two or three hours. So while the number or units of service may be dropping, our length of service may be still relatively equivalent to years gone by.

Mr. Wotherspoon: — Thanks for that information. And of course we recognize the incredible value of the home care supports that are extended, and just certainly want to make sure that needs are being met and that budgets are adequate to allow regions and communities to meet those needs. So it's a dramatic reduction in the number of visits. And I understand there might be other factors that influence that number of visits, or that one visit, you know, might be rather limited in scope as opposed to a broader one.

But certainly we have been, you know, we have had I know circumstances in my own constituency of individuals who have had reductions in service that have had a dramatic impact on their life. And I think it's in an area certainly that, you know, we want to make sure are supported.

I have a question about how you deal with wait-lists or what a wait-list looks like. Or do you have a wait list?

Ms. Hunt: — We occasionally have a, you know, a limited wait-list, but . . . They do exist at times, especially in nursing. Professional nursing visits may indeed, the demand may outstrip their availability. But those wait-lists are, if they do exist, are likely not to be long because we look and prioritize. Our team works, our leadership team works every day at assessing who's our priority today, has there been a new client brought on that needs service immediately, how can they shift individuals around. Instead of perhaps an hour visit, perhaps could 45 minutes provide adequate service and then they move on to the next individual.

We certainly have an opportunity to also redirect some of our priorities from the acute care environment due to some of our funding from Home First program. And that's very focused on ensuring that we delay admission to long-term care and really look at the home first and how can adequate supports be provided to keep individuals in their own home if at all possible.

Mr. Wotherspoon: — Thanks for your answers here today and the work that you've undertaken and the work you're committed to as well. And certainly I think it's up to the rest of us to make sure you have the resources that you need to get the job done. So thank you.

The Chair: — Are there any further questions? I just have a couple actually. Just a clarification around the . . . So we talked about nursing visits increasing and for the number, the reasons why the nursing visits have increased and the home support visits decreasing. And then one of the . . . You had pointed out that the number of visits might have declined but the hours could be the same. Do you have those hours recorded?

Ms. Hunt: — We do have them documented. We don't have them here today. We can provided the committee that information through the Ministry of Health.

The Chair: — That would be great. That would be very helpful. Thank you. Again I think in Mr. Ahmad's presentation one of the things that came up . . . And again this is about I think resources sometimes and making sure obviously that regions have the resources that they need to be able to deliver the services. Mr. Ahmad had mentioned the case of where three times a week people were getting services for, I can't even remember what it was and my notes aren't very clear here. And I've heard that case . . .

Mr. Ahmad: — Embolism stockings.

The Chair: — Embolism stockings. Needing it daily. And in fact people were getting it three times a week. And I've heard circumstances or situations like that in other regions as well. So to me I don't know if that's necessarily an organization of resources or just the reality that health regions face with . . . I mean there's not a magic pot of money and you have to decide where to spend money.

Ms. Hunt: — Without, you know, talking about specific patients, it is an . . . The assessor and the team that cares for that individual will look at how and what resources that individual may have. So indeed we may say that their pulmonary embolism stockings have to be, you know, they need support every day. But what perhaps our care plan doesn't indicate or the documentation is that perhaps their daughter is there twice a week to take them shopping. And that documentation is probably not as robust as it could have been. Yet they do get their stockings put on five times in that week or daily but not always by our staff.

So we do recognize that we need to review care plans, ensure documentation is accurate, and really reflect the care provided by family, by providers, and by the patient themselves because we are always trying to focus on independence.

The Chair: — For sure. Thank you. I know too, just in this particular auditor's report it's noted that in that particular year, in the 2013-14 year, that about 5.1 per cent of your budget was spent on home care services. Is that a number that you could . . . And obviously budget numbers are different in subsequent years. But has that number grown? Obviously there's the Home First program so I don't know if that's factored into that number.

Ms. Hunt: — We have our base funding and then we've had targeted funding through the Home First program. And certainly the Home First program has really allowed us those additional resources to expand our program around assessors, about additional nurses with a variety of skill sets, and really trying to transition individuals home as quickly as possible. I mean I would never say that we have enough resources but on the other hand, I think it's given this audit process and the opportunity to get the Home First dollars to really look at how we're delivering it, who is delivering services, and where. And do we actually accurately ensure that the services that we need to deliver are being delivered and also ensure that when someone no longer needs services that they're discharged from the program so that we can reallocate those services? So it really has given us an opportunity to ensure we've created some standard work for all of our population.

The Chair: — Sure. Can you just . . . I know Home First works differently in every community in which it's functioning. Can

you just tell us a little bit about how Home First works in your health region.

Ms. Hunt: — Well we have it integrated as much as possible within our existing home care program because often these patients may be discharged home. And we also have integrated with one of the nurse practitioners from our primary care program. We've had an opportunity to receive some additional resources there.

And so Home First is this continuum for us, that the nurse practitioner is going to the Victoria Hospital at 7:30 in the morning to communicate with her colleagues in the ER [emergency room] to see who's there. Can they be more appropriately cared for at home? Are there some things she can continue on? Is there something we can do differently to avoid hospitalization next time? And then to transition them back home. They will work with the Home First care staff. There might be a nurse assessor that would go to that home that day to work with family and then move on to their regulars, their regular home care providers if they were previously receiving home care services.

So we're trying to make this, wherever possible, a team environment to make the best use of those resources. They are within our existing home care program. Even our nurse practitioner has an office and exam rooms within the home care program. And they are, we are really working at making them a team, and I think that they've succeeded.

The Chair: — Thank you for that. Are there any further questions on this chapter? Seeing none, we have 12 recommendations with which we need to deal. Can I have a motion? Mr. Doke, I see you're ready with a motion.

Mr. Doke: — Thank you, Madam Chair. In regards to the 2014 Provincial Auditor report volume 2, chapter 36, recommendations 1, 2, 4, 6, 9, 10, and 11, we would concur with the recommendations and note progress towards compliance.

The Chair: — Thank you. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 36 that for recommendations no. 1, 2, 4, 6, 9, 10, and 11 that this committee concur with those recommendations and note progress to compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Another note, Mr. Doke?

Mr. Doke: — Thank you, Madam Chair. In regards to the 2014 Provincial Auditor report volume 2, chapter 36, recommendations 3, 5, 7, 8, and 12, we concur with the recommendations and note compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2014 Provincial Auditor report volume 2, chapter 36 that this committee concur with recommendations no. 3, 5, 7, 8, and 12 and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you, Ms. Hunt. I don't know if you'd like to make any final remarks.

Ms. Hunt: — No, I just want to thank the committee for the opportunity to be here today.

The Chair: — Thank you very much. Have a safe drive. And can we take a 10-minute recess here? All right. We shall recess for 10 minutes and come back at let's say 2:40.

[The committee recessed for a period of time.]

Regina Qu'Appelle Regional Health Authority

The Chair: — Welcome back everybody to Public Accounts. We will be now looking at more Health auditor's reports, specifically the Regina Qu'Appelle Regional Health Authority. I shall pass it off to Ms. Ferguson, and she'll pass it off to Mr. Ahmad to make some comments.

Mr. Ahmad: — Thank you, Madam Chair. Chapter 14 of our 2015 report volume 1 begins on page 147 and reports results of our audit on the effectiveness of Regina Qu'Appelle's processes for safe and timely discharge of patients from its largest hospitals in Regina.

For this audit the patient means an individual who stayed at least one night in an acute care facility. In other words, we did not include discharges of day surgery or emergency patients. Also we focused our work on the two largest facilities, that is Regina General and Pasqua Hospital.

Safely discharging patients from hospital requires a multidisciplinary approach. Although a physician ultimately determines when patients are medically ready for discharge, a wider network of staff and services are involved in discharging patients, arranging for their ongoing health care. Coordinated transition and effective communication may help reduce the number of admissions into the health care system that could result in better patient outcome and significant savings. Also timeliness of hospital discharge impacts patient safety, as the unneeded hospitalization increases the risk of hospital-acquired infections and the effective management of beds in hospital.

We concluded that the authority had effective processes to discharge patients from its two main hospitals except for the four areas reported in this chapter. We made 11 recommendations to help the authority to strengthen its processes.

On page 156 we recommend the authority follow up its policy to complete assessments of patients within 24 hours of admission. We found all of the assessments that we examined were completed within 48 hours instead of 24 hours. This departure from established policy could have a negative impact on patient care and discharge planning.

On page 157 we recommend the authority require health care professionals involved in patient care to prepare a comprehensive, multidisciplinary patient care plan. Nursing plans for each patient were in place, but they included limited

information from other disciplines like dietitians, pharmacists, and physiotherapists. While evidence existed that members of the multidisciplinary team were consulted on various patient care matters, there was no documented comprehensive multidisciplinary plan. Although the authority had developed a template for such plans, it was not used.

[14:45]

On page 158 we recommend the authority implement a strategy to facilitate communication with physicians to better coordinate patient discharge time frames. The authority used multidisciplinary team meetings to discuss patients' clinical readiness for discharge and the estimated discharge date. However, management stated while the multidisciplinary team provides its best estimate of discharge date, the physician subsequently often changed those dates. The authority recognized that increased physician involvement is necessary to improve patient care and discharge planning; for example, multidisciplinary meetings can be more effective if held when physicians can attend.

On page 159 we recommend the authority follow its policy to document patient instructions and discuss those instructions with patients before discharge. We found the patient files that we examined did not always include patient instructions as required by the standards. To appropriately prepare patients for discharge, the authority's standard of nursing care requires each patient receive patient instructions including follow-up care, follow-up care with health care providers, medication list, a referral, and other necessary instructions.

On page 160 we recommend the authority use aids such as whiteboards at the bedside to provide patient with critical information about estimated discharge date and goals. We found whiteboards in patient rooms were often left blank. Use of aids by multidisciplinary teams can help patients understand the barriers they need to address prior to discharge.

On page 163 we recommend the authority ensure physicians complete discharge summary information on a timely basis as required by its rules for medical staff. For the patient files that we examined, nearly one-half of the summaries were not recorded and signed in a timely manner, and for over 10 per cent of the files we examined, there was no evidence that discharge summaries were forwarded to the patient's post-discharge health care provider. This increases the risk of errors in medication continuity and inappropriate post-discharge care.

On page 164 we make two recommendations. We recommend the authority establish a policy for completing medication reconciliations prior to discharging patients, and require staff to follow that policy for completing medication reconciliations. A medical reconciliation requires a systematic and comprehensive review of all medications a patient takes to ensure medications added, changed, or discontinued are carefully evaluated at admission and discharge. This helps ensure accurate and comprehensive medication information is communicated across transition of care to another service provider or home.

We found the authority did not have an established policy requiring medication reconciliation at discharge. For almost all of the patient files that we examined, discharged patients received a list of medication as part of their discharge instructions, but in the majority of cases medication reconciliations were not prepared and signed by prescribing physicians. Lack of medication reconciliations increases the risk of inaccurate medication information being communicated to patients and post-discharge health care providers.

On page 166 we recommend the authority develop strategies to achieve its target to discharge patients early in the day. The authority has established a target for 80 per cent of the discharges to occur before 2 p.m., with compliance expected by 2019. Discharging patients earlier in the day improves patient flow in hospitals because new emergency admissions awaiting beds can leave the emergency department sooner, reducing emergency waiting backlogs. This in turn can increase patient satisfaction. We found the authority had not developed strategies to help achieve its early-in-the-day discharge target.

On page 167 we recommend the authority establish performance-based measures and targets for patient discharge. Performance-based measures help enable hospitals to monitor the progress of initiatives and track performance over time. We found that while the authority had developed some measures, it needed additional performance-based measures to better highlight factors that may prevent timely and safe discharge.

And finally on page 168 we recommend the authority report performance-based measures and targets for patient discharge to its senior management and the board.

While the authority gave the board quarterly information on provincial strategies — such as better health, better care, better value, and better teams — it did not provide information on patient-discharge-specific measures by years, such as delayed discharge by cause of delay, post-discharge patient satisfaction, etc. Such information would help senior management and the board understand factors contributing to and inhibiting timely and safe patient discharge. That concludes my remarks.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to make some comments on this particular chapter?

Mr. Hendricks: — Sure. Thank you. You know, the auditor's report is very timely. As a health system we're very focused on flow through the system and safe flow through the system.

As you know, we have our ED [emergency department] waits initiative which is trying to reduce wait times in the emergency room but also, in terms of meeting our surgical targets, having people discharged in a timely fashion to either home care or to long-term care. It's such a complex system and there are so many players in this. And I think the auditor's actually identified a number of areas that we feel are key priorities in addressing this issue.

You know, to really get at this, you have to have the participation of all your health providers in coordinating and providing a multidisciplinary approach to health care. And as the auditor's identified, you know, there are a number of challenges with that, and a lot of these issues are cultural and they're long standing. But you know — I'll have John Ash speak in a minute — you know, Regina Qu'Appelle is doing a

lot of work or has done a lot of work over the last few years to try and make progress on these issues and has made significant progress.

So with respect to the specific recommendations on page 156 that RQHR [Regina Qu'Appelle Health Region] ". . . follow its policy to complete admission reassessments on patients within 24 hours . . ." in some cases this was done very well by hospitals and such, but again not all patients were having it done with 24 hours as the auditor mentioned, in some cases 48 hours. The region will conduct a root cause analysis by September 30th, 2015 to identify factors contributing to non-compliance of its standards and policies. And based on that, the outcome of that analysis, specific educational strategies will be established to support the regular audit process. This recommendation is expected to be fully implemented by March 2017. So that work is in progress.

On page 157, we recommend that RQHR ". . . require health care professionals involved in patient care to prepare a comprehensive, multidisciplinary patient care plan." To support further advancements in care plan development and communications, the region is reviewing the outcomes of lean work conducted in the area both locally and among other health regions. Additionally, the region will conduct a review of leading practices to assist in identifying strategies to further enhance how care plans are established and communicated amongst members of the team. Completion of this enhanced activity is scheduled for March 2017. As well, information is being shared in daily multidisciplinary rounds and key pieces of information are documented in the care plans so that it is readily available for all disciplines. But as I said earlier, you have to have participation by all members of the multidisciplinary team for that to work effectively.

On page 158 we recommend that the RQHR ". . . implement a strategy to facilitate communication with physicians to better coordinate patient discharge time frames." The region has developed standard work which focuses on the coordination of patient discharge plans and dates. In addition the region is planning to implement an accountable care unit pilot starting December 2015. This pilot will see the delivery of daily structured interdisciplinary bedside rounds which supports the concept of localizing physicians to a specific unit. This will encourage physician engagement and improved communication regarding the patient's care plan and discharge time frames. So again, that's in progress.

On page 159 we recommend RQ [Regina Qu'Appelle] ". . . follow its policy to document patient instructions and discuss those instructions with the patients before discharge." Again, the region will conduct a root cause analysis by October 30, 2015 to identify factors that are contributing to non-compliance with its already existing standards of care and policies. Based on the outcomes of this analysis, specific educational strategies will be established, supported by regular audit processes. The recommendation is expected to be fully implemented by March 31st.

On page 160 we recommend that RQ "consistently use aids." Examples that the auditor gave were whiteboards at the bedside to provide patients with critical information about the estimated discharge date and goals. The region has established standard work to support communication of critical care discharge and discharge plan information, including the estimated date of discharge. Almost every patient coming in should have an estimated date of discharge, and that can be changed through the multidisciplinary rounds, depending on the patient's condition. The standard work has been reinforced with nurse managers and will be accompanied by a random audit process.

In addition the region is participating in a provincial level standard work that will incorporate the use of visual aids to assist in communication of important information to patients. So again you know, on that recommendation, the region believes that it has implemented the spirit of the recommendation.

No. 6 on page 163, we recommend that RQHR ". . . ensure physicians complete discharge summary information on a timely basis as required by its rules for medical staff." The region continues to audit the timely completion of discharge summary information by physicians and has established a process whereby direct feedback is provided by the vice-president of physician services and the senior medical officer on those summaries to the physicians.

The region has seen significant improvement since the process began. The applicable policies regarding health record completion have been amended and practitioner rules to support more timely completion of health records are in the process of being updated. Again they expect full implementation by March 2017, so that's in progress.

Recommendation no. 7, we recommend that the RQHR ". . . establish a policy for completing medication reconciliations prior to . . . [discharge planning]," the region has addressed this recommendation by establishing a regional policy regarding medication reconciliation on transition. So they believe they've implemented the response to that recommendation.

On page 164, we recommend RQ ". . . require staff to follow the policy for completing medication reconciliations prior to discharging patients," the region has established a regional policy regarding medication reconciliation on transition, as I said. Staff will receive the necessary education and an audit process will be established. To support this work, a rapid process and improvement workshop, which is a lean process, will be held in October 2015 to focus on improving medication reconciliation on transition to acute or home care. This recommendation again is expected to be fully implemented by 2017. So on that one, the region is saying that it is in progress.

On page 167, we recommend that RQ ". . . develop strategies to achieve its target to discharge patients early in the day," before 2 o'clock, in February 2015 the region established a target of 80 per cent of its discharges occurring before 2 p.m. as its initial goal. It's expected the target will evolve to more appropriately reflect performance measures. The balanced discharge timelines would save patient care. Completion of this activity is scheduled for March 2017.

On page 167, recommendation no. 10, we recommend that Regina Qu'Appelle ". . . establish performance-based measures and targets for patient discharge." As of January 2015, the region has established performance-based targets for

system-wide patient flow, including targets for patient discharge.

Vice-presidents report out twice monthly on various patient flow metrics at the corporate patient visibility flow wall, and in June 2015 the region engaged all clinical areas in a two-day planning session that identified key flow performance targets and strategies over the next four years. Many of the targets contribute directly and indirectly to the delivery of safe and efficient patient discharge processes. So they feel that they have established those performance-based targets and they're reporting them.

Recommendation no. 11 on page 168, we recommend that RQHR ". . . report on performance-based measures . . . for patient discharge to its senior management and Board . . ." The region reports provincial targets and outcomes on patient discharge to its board of directors on a quarterly basis. As of January 2015 vice-presidents again report out twice monthly at the visibility wall, and so again the region feels that it's complying with that recommendation. And that's all.

The Chair: — Thank you, Mr. Hendricks. That's many recommendations that you had to talk about. I'd like to open up the floor for questions. Just with respect to sort of a descriptor on a few of these recommendations, there's the discussion about a root cause analysis. So I'm just wondering what that will look like.

[15:00]

Mr. Ash: — Madam Chair, the root cause analysis is really understanding that there are multiple factors that are contributing to staff not complying with either the admission assessment or other . . . And we really want to make sure we're understanding those clearly so that we can focus or adjust our current policies or standards and focus our training, education, or re-education to ensure that we have compliance and to make sure our audit plan is factoring those things so that we ensure that we have continuation compliance and really sustained change.

The Chair: — Could you just maybe describe a little bit, is that like looking at literature, looking at practices? Like what is all involved in . . .

Mr. Ash: — Primarily it's understand the work itself. So I'm going to focus on the admission assessment. And the question is, why is it predominantly happening at 48 hours as opposed to 24 hours, and really understanding the work that's occurring on the unit. And that assessment really contributes to identifying potential risks or barriers that may contribute to discharge. Our initial assessment is the units are primarily focused on receiving the care, assessing the patient initially, and dealing with the immediate care needs as opposed to kind of looking more to the discharge strategy, understanding best practices that discharge planning occurs on moment of admission. But we want to understand those factors clearly so that we can make sure that we either adjust or develop our systems or training to support that change.

The Chair: — So that's working with the unit itself and talking to everybody on the unit and getting their perspective.

Mr. Ash: — Yes.

The Chair: — Just with respect to that first recommendation around the discharge completing within 24 hours and instead it's 48 hours, I think you've answered this already. But you said the focus seems to be one of the challenges is that staff is really focused on that immediate initial need. Can you maybe speak a little bit more about what you see as . . . obviously the root cause analysis will tell you more, but what you perceive to be some of the challenges with that 48 hours versus the 24 hours.

Mr. Ash: — Madam Chair, as indicated, I think that rightly so the staff, the nurses and other staff, are focused primarily on ensuring the patient is stabilized. You know, orders are being executed. Families are being engaged and discussed. The rest of the care team's involved in regards to what is the current presentation or chief complaint of the patient, that they're managing those issues because they're very, some of them very time sensitive. So they're focusing on the now. Rightly so, because those are the immediate patient needs. And then unfortunately because of sometimes complexity and other issues that are going on, that component that this recommendation is speaking to doesn't occur within the first 24 hours.

The Chair: — Thank you for that. Mr. Wotherspoon.

Mr. Wotherspoon: — You have bright questions and satisfied most of them there I think, so thanks for the work. And you know, I think that the questions I would have had initially were just around what seems to be a protracted period of time to respond to the policy around the 24-hour, the response within 24 hours of admission and a timeline towards implementation of 2017. And I think, Ms. Chartier, you've touched on that question. So I don't have any other further questions at this time right now.

The Chair: — Are there any further questions on this chapter? Mr. Marchuk.

Mr. Marchuk: — Thank you for the information. I'm wondering about actual admissions. We had an experience this summer where we understood there to be a difference between outpatient admission and in-patient admission. Is that accurate?

Mr. Ash: — That is correct. Patients are registered or admitted as an in-patient or an outpatient.

Mr. Marchuk: — So as an outpatient that would be a doctor's referral, right? To appear at the hospital the next morning or whatever.

Mr. Ash: — If that visit is for perhaps a consult. So an emergency department visit is considered an outpatient visit. You are considered an in-patient once you are admitted to an in-patient ward.

Mr. Marchuk: — How do the two talk to each other? Outpatients admission and in-patient admission, is there some way they communicate?

Mr. Ash: — Yes. When a patient is, whether they're in an outpatient clinic or in the emergency department or ambulatory

care or whatever, and the decision is to admit the patient, the emergency room physician — I'll use that as an example — does not admit the patient. The emergency room physician needs to identify an admitting physician, so most responsible physician. So there is a telephone conversation identifying the patient's complaint and the issues that need to be resolved. The admitting physician would accept that patient and identify admission orders and what have you which then are executed by the in-patient unit, which is much of that work that we're speaking about the delaying potentially that 24 to 48 hours.

Mr. Marchuk: — Okay, thanks.

The Chair: — Are there any further questions? Mr. Wotherspoon.

Mr. Wotherspoon: — Sure. Just on the aspect of reconciliation of medications prior to discharge, there's going to be a workshop that . . . You've identified a rapid process improvement workshop will be held in a month's time I believe, and this will focus on improving reconciliation on transition from acute to home or home care. Can you just talk a little, you know, share a little bit about what that looks like and how that's going to provide the outcome that's desired.

Mr. Ash: — Certainly, and I think what's important context here is Accreditation Canada has a number of accreditation standards or required standards around med reconciliation, and in aligning with that and this auditor's recommendation, we're making sure we're addressing that kind of full spectrum of whether it's accreditation standards or audit recommendations.

So specifically to the rapid improvement workshop, it's really looking at what processes do we need to formalize and have in place, and it's really about bringing together a significant amount of resources to deal with that problem in a very short period of time. So it's really, as the name says, it's rapid change to kind of move us to the next level. And we know that some of our, you know, whether it's to another acute environment, another acute hospital or to home care, normally those patients have sometimes complex medication-related issues. So we want to kind of go after that specific issue and bring together, through this rapid improvement process, a number of resources to really focus and nail down those processes in a very short period of time to really take us to that next level and address this recommendation.

Mr. Wotherspoon: — Thanks for that information. As far as recommendation no. 9 about the discharges being earlier in the day and I think there's been the target that's been noted by the region of having 80 per cent of discharges occurring before 2 p.m., I'm wondering where you're at right now. That was set in February. What's the experience been the past few months and currently?

Mr. Ash: — Well it depends on the unit itself. So more predicable units, for example, surgical units where patients are on pathways, there's a kind of predictable piece. But you'll note in our comments we're actually looking at adjusting that target because what we're finding through talking to other jurisdictions, by making that kind of hard and fast target at 2 p.m., sometimes what ends up happening is people say, well I want to get this person out in the morning because I'm, you know, praised for that, if you would. So instead of discharging them tonight, I'll wait till tomorrow.

Or it doesn't take into effect the actual patient care needs of the patient, more importantly, and sometimes there's blood work or there's things that have to happen after they have breakfast or after they have lunch. And we don't want to kind of push people out. We want to allow them to progress appropriately in their care plan, and once they have achieved completion of their care plan, then they need to be discharged.

So our focus is going to be shifting more towards, and this contributes to some of the recommendations, do you have a robust care plan and is it progressing and are you engaging all the necessary stakeholders so that their length of stay is appropriate?

Mr. Wotherspoon: — So the 2 p.m., the time will be, I guess, that'll be likely changed and pulled out and it's going to be around the adequacy of the care plan, and then making sure that . . . I mean the time of release would be a component of that, but you want to make sure that it's an optimal environment for the discharge.

Mr. Ash: — Yes. And we're are actively looking at how kind of high-performing organizations create metrics and processes to measure that because we want to make sure that our focus is on safe, quality care as opposed to moving people out the door quickly.

Mr. Wotherspoon: — Thank you.

The Chair: — Any further . . . Oh, Mr. Hart.

Mr. Hart: — Thank you, Madam Chair. In this whole area just being discussed, I have had over the years one or two constituents or families come to contact my office about what they perceived as family members who were in one of the acute care facilities being, in their opinion, forced out before they were ready to leave the hospital.

And you know, I mean, you're never really sure, you know, where all the facts are in a situation like that. But I find this discussion about having a goal of discharge by 2 p.m. and, if there are people who are rigid, you know, trying to adhere to that and perhaps maybe . . . As a result of the discussion, it just seems to shed some additional light on some of those complaints that we've dealt with in the past.

And I was certainly happy to hear that, you know, the well-being of the patient and patient care is the most important thing rather than adhering to some target for discharge that certainly, under normal circumstances and routine procedures, is probably a target that's worth achieving. But we certainly need to have a fair bit of flexibility that's dependent on the condition of the patient. And I just thought I'd like to put those comments on the record. Thank you.

The Chair: — Mr. Michelson.

Mr. Michelson: — I just want to follow up on a comment that was started by Mr. Marchuk. I think the communication, and I know that's not with . . . This isn't pertaining to discharging or

admitting. But we had some experience this summer with the health authority in Regina too. And my daughter had an accident and had an operation on her neck with her vertebrae. And the doctor's recommendation, he said she can't have a pillow for at least three weeks. And back in the room, the nurses are starting to put a pillow under her head.

It was the same with administrating some drugs. One couldn't be administered with another one. And if my wife wouldn't have been there, that would have been . . . They would have been put in together and it just . . . She's not a medical professional, but just following up on what she had heard.

Those kind of communication errors were very concerning to us. And I just wanted to put that on the record because I think that's something that really has to be first and foremost as far as patient care is concerned.

Mr. Ash: — I would agree 100 per cent that really discharge planning or admission planning, or whatever it may be, is communication. And that is the reference to the accountable care unit pilot that we're putting in place, where it physically embeds the physician with the rest of the care team on the unit. So they become a team.

One of the challenges we have with our current care models in place is that physicians have patients on 5, 6, 10, 15 different wards, so there is no opportunity for them to develop a relationship or have any kind of standardization or consistency with the rest of the care team.

And based on best practice, an accountable care unit . . . We are actually very excited about the implementation of this. We've already started and we're already seeing some significant value from a patient safety and quality standpoint. A very small piece, but in the 16 weeks that we've put the multidisciplinary rounds or embedded the physician, we have not had a single client complaint from that demographic of patients. So we're very encouraged. And this is early on so we're very much encouraged.

And all of that, the accountable care unit work and much of the work that we're doing contributes directly and links to, as Mr. Hendricks indicated, the provincial priority on ED waits and patient flow. So we are connected very much and sharing our information and ideas and learning collectively as a province on some of this information. So your point is well taken.

Mr. Michelson: — Thank you.

The Chair: — I did have a question I was going to ask about the accountable care unit and how that works. So you've already started it. I noticed it wasn't to start until December 2015. But can you describe it a little bit more about how localizing physicians to a specific unit works? And has there been any . . . has it been all positive feedback from physicians, that notion of continuity of care? How has that . . . Can you talk a little bit more about that pilot?

Mr. Ash: — We haven't started the pilot in that there's a number of elements that need to be in place. We've worked, we've started implementing some of those elements and we're already seeing significant value for the patient. An accountable care unit is about, as I indicated to the previous member, it's about embedding the team on the unit and localizing all of the resources necessary for patient care based on the needs of the demographic that are typically on a unit. So a surgical unit may be different than a medical unit.

[15:15]

So you would have, obviously, the nursing staff. The physician would be physically on that staff, and you would have an appropriate load of patients. So on 4A — which is the unit that we're piloting this at, at the Pasqua Hospital — we have two hospitalists working seven days a week, 10 hours a day, and they're on call for the alternate time. But they work with the same group of nurses, the pharmacy, occupational therapy, speech therapy, so forth, and they do daily rounds every single day at the exact same time. So there's a degree of predictability.

So imagine you have a family member in the hospital. You're caring for them. You know that at 10:15, the team is going to come into your room and they are going to discuss, with you and the patient, the progression of care and what's happening, as opposed to talk at you. And we are seeing some absolute phenomenal results from that.

Some of the other elements that we're working through is shift-to-shift handover, making sure we have clear, consistent standardized communication, nurse-to-nurse hand-off that typically would be at the bedside. So two nurses are seeing, as opposed to hearing in a verbal report. Case in point, the nurse may say, they have a small red spot on their back. What is small to me? What is small to you? So you come in, you see small. Well that's small, and I say the same thing to the next nurse. Pretty soon small is this big. But when you have two eyes on the same thing, you're able to react sooner and manage the patient.

Kind of building on that example, a patient was getting ready for discharge, you know, was a couple of days out from discharge, and there wasn't a lot of care needs. And staff were, why are we still doing rounds? Why are we still doing this? Because they don't have, you know, there's no ulcers, no bedsores. And the physician rightly said, that's exactly the point is because we're here every day providing care for this patient, they don't have bedsores or ulcers. So if you talk to patients, they say, well why aren't you doing that all over? Right? But this is about kind of reorganizing how we provide care. And as I said, we're very much linked to the provincial hoshin on sharing our learnings and working with our ministry partners.

The Chair: — So this is on 4A at Pasqua?

Mr. Ash: — That is correct.

The Chair: — And forgive my ignorance but which one, what is 4A?

Mr. Ash: — 4A is a medical unit on the Pasqua Hospital.

The Chair: — Okay. And do you have sort of a length of time that you'll do this before you assess success?

Mr. Ash: — We are targeting a six-month pilot, and we were

actually engaging our research resources within our region because we want to conduct formal research on this to provide confidence in the outcomes that we're getting so that we can make decisions appropriately on where we go next.

The Chair: — Thank you for that. Sounds interesting. It sounds really quite positive. Any further questions on this particular chapter? Seeing none, we have several recommendations with which we need to deal, 11 of them. Could I have a motion?

Mr. Doke: — Thank you, Madam Chair. In regards to the 2015 Provincial Auditor report volume 1, chapter 14, recommendations 1, 2, 3, 4, 6, 8, 9, we would concur with the recommendations and note progress towards compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved that for the 2015 Provincial Auditor report volume 1, chapter 14 that this committee concur with the recommendations no. 1, 2, 3, 4, 6, 8, and 9, and note progress to compliance. Any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Doke.

Mr. Doke: — Madam Chair, in regards to 2015 Provincial Auditor report volume 1 chapter 14, recommendations 5, 7, 10, and 11, we would concur with the recommendations and note compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has moved for the 2015 Provincial Auditor report volume 1 chapter 14 that this committee concur with recommendations 5, 7, 10, and 11, and note compliance. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. We shall move on to the next chapter. Thank you very much for your time, and I will pass it off to the Provincial Auditor. We will be talking about the Heartland Regional Health Authority . . . [inaudible interjection] . . . Oh one more Regina. No, my apologies. Thank you. So we will be looking at chapter 26 for the RQHR.

Ms. Ferguson: — And Mr. Ahmad will make a very brief presentation on this one.

Mr. Ahmad: — So chapter 26 begins on page 271. It reports the result of our follow-up work of nine recommendations we made in 2013, and they relate to Regina Qu'Appelle's processes to support efficient use of surgical facilities.

This is our first follow-up and we are very pleased to say that the authority has implemented eight of the nine recommendations. I will briefly address the one outstanding recommendation.

The outstanding recommendation is at 3.2 on page 273. This recommendation asked the authority to establish efficiency-focused performance measures and targets for assessing the use of surgical facilities. While the authority had established many efficiency-focused measures by March 31, 2015, it had not set targets.

Setting targets helps agencies determine the nature and extent of improvement expected for a stated period. This in turn provides critical information when determining resources necessary to make improvements. And that concludes my remarks.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to make some comments about this chapter?

Mr. Hendricks: — I, like Mr. Ahmad, am very pleased about the region's progress on this particular chapter and particularly because the last outstanding recommendation that has been noted by the deputy auditor on page 273, "We recommended that Regina Qu'Appelle . . . establish efficiency-focused performance measures and targets for assessing the use of . . . [regional] facilities," the region has implemented this recommendation now.

They believe by continuing to actively monitor quality, cost, delivery, and safety and morale, measurements and targets are now set on a regular basis. Measures compared to targets are reviewed biweekly on the surgical services line wall walk. Targets are reviewed regularly through the regional and portfolio planning process. For example, the region continues to monitor surgical volumes against funded capacity targets on a weekly basis.

As well the region has completed a variety of improvement work in the surgical areas and is engaging in additional events and projects during 2015-16 aimed at decreasing waste, eliminating defects, and improving information and patient flow and increasing value and efficiencies. So the region believes that they are now in compliance with this recommendation.

The Chair: — Thank you, Mr. Hendricks. Are there any questions on this particular chapter? Mr. Wotherspoon.

Mr. Wotherspoon: — Just to pass along I think that it looks like there's a significant body of good work to address these recommendations. So thank you for all that work and to all that have been involved in it.

The Chair: — Any further questions? Seeing none, as there's no new recommendations, we just need a motion to conclude consideration. Could I have that motion?

Mr. Doke: — So moved, Madam Chair.

The Chair: — Thank you. Mr. Doke has moved that for the 2015 Provincial Auditor report volume 1, chapter 26, that this committee conclude considerations. Is there any further discussion? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on. Thank you very much. If life only went that quickly all the time.

Heartland Regional Health Authority

The Chair: — Moving on to the Heartland Regional Health Authority, I will pass it off to the Provincial Auditor for Mr.

Ahmad's remarks.

Mr. Ahmad: — Thank you very much, Madam Chair. The chapter begins on page 235. This chapter describes the result of our audit of medication management in long-term care facilities of Heartland Regional Health Authority.

The authority has 14 long-term care facilities with 483 beds in total. Under the law, RHAs are responsible to provide health care to individuals residing in long-term care facilities. These facilities provide a place of residence for individuals who require continuous health care when their needs can no longer be met in their own homes. RHAs must follow the ministry's program guidelines for planning and managing care for residents.

Planning for safe and effective medication management is critical for residents who often have complex health needs. Developing and implementing a medication aspect of a care plan for residents involves coordination between physicians, pharmacists, nurses, and other caregivers. The Canadian Patient Safety Institute has identified emerging safety issues relating to medication use in long-term care settings, including inappropriate medications. Potentially inappropriate medications are identified and listed on several lists such Beers list, ISMP [Institute for Safe Medical Practices] list, and the START [screening tool to alert doctors to right treatment], STOPP [screening tool of older persons' potentially inappropriate prescriptions] criteria. The ministry recognizes these lists as appropriate standards of care.

Our audit assessed Heartland's processes to manage medication plans for residents of its long-term care facilities for the year ended August 31, 2014. We did not question medical decisions or examine medication plans at the authority's acute care facilities. We concluded that the authority did not have effective processes to manage medication plans for residents in long-term care facilities. We made 17 recommendations.

On page 241, we recommend the authority have comprehensive policies for medication management that are aligned with the ministry's guidelines. Although the authority has some medication management policies, they were not comprehensive. For example, the policies did not require medication plans, reviews of medications, staff training requirements. Nor were those policies aligned with the ministry's guidelines. The authority last updated its medication policies in 2011 while the ministry revised its guidelines in 2013.

On page 242, we recommend the authority establish a process to identify trends, needs, and issues related to medication management in its long-term care facilities. The authority did not have such a process. Also, it did not verify the accuracy or completeness of information it reported to the ministry. Furthermore, management could not tell us how many residents received potentially inappropriate medications, how many non-critical errors occurred, or the frequency of its medication review.

On page 242, we recommend the authority develop a regional approach for the use of medication in its long-term care facilities. The authority did not have a regional strategy for medication use in its long-term care facilities or targets relating to medication use.

On page 243, we recommend the authority clearly communicate its approach for medication use to long-term care residents and their families, staff, and health care providers. In its client family information handbook, the authority provides some information on its least restraint policy. The policy recognizes that sometimes residents need some restraint to protect themselves, other residents, or staff from injuries due to fall, aggressive behaviour, or wandering. The policy requires staff to exhaust all alternatives before using restraints. However, we found evidence of such assessment in only 24 per cent of the files we tested. Insufficient clear communication, staff training, or proper supervision can contribute to staff not complying with policies.

On page 244, we recommend the authority implement an education program for staff who develop and deliver medication plans in its long-term care facilities. Authorities, nursing staff, and clinical educators told us nurses maintain their professional development in their own time and the educators did not specifically address medication as part of the region's education plan.

On page 245, we recommend the authority use a multi-disciplinary approach for finalizing medication plans for long-term care residents. The authority had a consistent process for developing medication plans that involved nursing staff and physicians. However, for the files we examined, there was no evidence that a pharmacist had reviewed the medication lists. Not involving pharmacists increases the risk of inappropriate medication plans, that is, unidentified medication complications or conflicts.

Also on page 245, we recommend the authority establish standardized documentation requirements for medication plans of its long-term care residents. None of the documentation of the medication plans that we tested for residents admitted during the audit period had all critical information. For example, plans did not set out the method of dispensing, that is, take with food or empty stomach. Also the authority did not require staff to document high-risk medication regimes as defined by the ministry's guidelines.

On page 246, we recommend the authority develop a policy for enhanced planning for residents with complex medication needs, including the use of appropriate assessment tools. We found the authority did not document high-risk medication regimes or flag residents at high risk of adverse drug reactions. Best practices indicate health care providers should try non-medical interventions before using chemical restraints for residents with negative behaviour like aggression towards others and risk of wandering. However the medication plans that we tested had no evidence of discussion of alternatives or possible adverse effects of medications.

On page 247, we recommend the authority require that all appropriate approvals and informed consent for a resident's medication be received from the resident or designated decision maker. While the authority required physicians to sign medical reconciliations on admission and any subsequent changes, it did not include informing residents or designated decision makers about high-alert medication in the plan. Residents and their

decision makers need such information to make informed choices in consultation with their physicians.

[15:30]

On page 248, we recommend the authority follow its policy for documenting in residents' medical records all the medication-related activities. The authority's policy required it to maintain health records, and it used medication administration records as its health record. However we found the record was not always complete and up to date. Only one-third of the monthly records that we examined were complete and signed off.

On page 250, we recommend the authority follow its policies for medication changes for its residents. The authority policy required an assessment of a resident's pain and behaviour each quarter or when the resident's condition changed. Seventy-one per cent of the files we examined did not have evidence of pain assessment, and 85 per cent of them did not have evidence of behaviour assessment. Lack of timely assessments may put residents at risk of receiving inappropriate medication.

Also on page 250, we recommend the authority implement a policy requiring informed written consent from residents or their designated decision makers for changes in high-risk medication. We found the authority did not have any specific policy regarding consent to changes in treatment including medication. Requiring written consent helps ensure residents and their decision makers are aware of the changes in medication.

On page 251, we recommend the authority follow its policy to obtain written consent before using medication as a restraint for a resident. The authority restraint policy requires a written consent prior to any form of restraint application. Only 27 per cent of the files we examined included notes of consultation with the resident or designated decision maker about medication changes. Only one file had evidence of agreement to the chemical restraints.

Also on page 251, we recommend that the authority consistently collect and document transfer information for residents who are transferred to its long-term facilities. Twenty-three per cent of the files that we examined for transfer of residents from acute care or other long-term care facilities did not have completed transfer forms.

On page 252, we recommend the authority track for analysis and reporting all information on prevalence of medication use and medication error in its facilities. Other than the antipsychotic medication that the ministry requires, the authority did not track any of the medication information on the prevalence of use of those medications. During our interview at some facilities, staff mentioned many examples of medication error but the facility could not provide copies of the related incident reports.

On page 253, we recommend the authority follow its policies to have staff report moderate to serious complaints relating to long-term care to its quality improvement and safety department. Although the authority established policies requiring staff to report moderate to serious complaints to its quality improvement department, management indicated that the practice was to resolve moderate to serious complaints at the service delivery level and not report them to the quality improvement and safety department. This results in the authority not tracking or being aware of the nature and extent of all moderate to serious complaints. This increases the risk of the authority not identifying or resolving issues in a timely and effective manner.

And finally, on page 254, we recommend the authority collect and analyze information to improve medication plans for its residents. We found it did not collect such information like the number of residents receiving regular medication reviews, pain and behaviour assessments prior to implementing restraints. Collection and analyzing such information could help the authority to plan effective medication use for residents.

That concludes my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to make some comments?

Mr. Hendricks: — Yes, thank you, Madam Chair. Obviously the Ministry of Health and the leadership of the Heartland Regional Health Authority take these recommendations very seriously. You know, I think that when we look at the seniors' environment and particularly the number of medications that many seniors are on — oftentimes it's over 10 medications in any given time — medication management and attention to it is critical. It's a safety issue, and as a health system we're very focused on addressing patient safety issues.

And not unlike what you heard from Regina Qu'Appelle, medication reconciliation, medication reviews, that sort of thing, are critical and just become all that more complex when you're dealing with seniors. We identify seniors as being on 13 or more medications as very complex, and they should have regular reviews. And in fact, the requirements are outlined for this in our program guidelines for special care homes.

And so one of the things that we're doing — and this is in response, I think, to some of the challenges that we've experienced in this area — is we're educating regions. We've engaged in a formal process to educate regions on exactly what the requirements of those guidelines are and what the expectations and accountabilities are. Because while people in program branches or administration might know them, how they're actually interpreted on the floor in each long-term care home could be different. And so that's an important thing that we want to get about.

So with those comments, again as I said, this is a system focus and one that the leadership of the system and the region are very committed to addressing. So with that, I can go through some of the specific recommendations and the actions that have been taken to date, if that's okay.

The Chair: — Yes, that would be great.

Mr. Hendricks: — The first recommendation is page 241. We recommend that the Heartland RHA ". . . have comprehensive policies for medication management that are aligned with the Ministry of Health guidelines for its long-term care facilities."

The region will review and revise existing medication management policies and develop new policies as necessary by September 30, 2015 to ensure alignment with the ministry's guidelines. So that is in progress.

On page 242, the auditor recommends that the Heartland Health Region " . . . establish a process to identify trends, needs, and issues related to medication management in long-term care facilities." The region has developed an audit tool for baseline data collection which will identify trends, needs, and issues. The audit tool tracks pain assessments and least restraint processes for chemical restraints, including appropriate assessments and consents.

Facility care teams have conducted a detailed medication review process using the minimum data set or what we call MDS data to identify opportunities for individual client improvement. On a go-forward basis, MDS data will be reviewed quarterly with respect to those clients who trigger the quality indicators, who trigger the quality indicators for potentially inappropriate medication use in long-term care. The region has formalized the quarterly multidisciplinary medication review process with a target of 100 per cent compliance by March 31st, 2016.

And lastly, the region tracks medication errors through a regional incident management process. All code 3 and 4 incidents reported through the process require an investigation. The region's quality department monitors this process to ensure that all incidents at those levels are completed and include recommendations for improvement strategies.

The third recommendation on page 242: we recommend that Heartland ". . . develop a regional approach for the use of medication in its long-term care facilities." The region has developed a policy and procedure outlining its long-term medication management in long-term care. The policy includes a medication plan, a multidisciplinary approach to medication management, and the identification of high-risk medications. Targets for medications' use have been established using this policy as well as the Ministry of Health's targets for the MDS and quality indicators for potentially . . . appropriate medication use in long-term care. Further targets will be established based on the data collected from the baseline audit in March 2015 and the expected implementation date is again by November 30th, 2015, I believe.

On page 243, the fourth recommendation: we recommend that Heartland ". . . communicate its approach for medication use to long-term care residents and their families, staff, and [other] health care providers." In fall 2015 the region will communicate its new medication management policy and procedures to all stakeholders including the ones named: nursing staff via local RPN [registered practical nurse], LPN [licensed practical nurse] meetings; physicians, through the practitioner advisory committee and the regional medical advisory committee; face-to-face meetings with pharmacists and with HHR [health human resources] staff, through clinical education and orientation days; and clients and families, via letters and by inclusion in the client family handbook.

On page 244, we recommend that Heartland ". . . implement an educational program for staff who develop and deliver medication plans in its long-term care facilities." The region has been working on and implementing an educational program for staff on the development and delivery of medication plans. Initial gentle persuasive approach training for all staff has been completed in 14 long-term care facilities. In addition, a business case has been developed for ongoing training for new staff as well as to recharge or refresh training for existing staff.

The gentle persuasive approach, we hope by educating more staff in those techniques, we can reduce the utilization of anti-psychotropic drugs for difficult dementia patients and that sort of thing. And we're spreading that across the province.

By September 30th, 2015, clinical nurse educators will revise the nursing practice references policy to include accessing information other than by printed books, for example, the use of pharmacists and many online resources such as medSask and our pharmaceutical information system, and adding as an exhibit the quick reference guide to assessing medical information. As well, education of staff on medication management will be ongoing at the regional clinical orientation days instructed by the region's clinical nurse educators. By December 30th, 2015, all nursing staff, physicians, and pharmacy staff will have training on the new program, Lexicon. This program consists of information on medication, diseases, and includes patient education handouts. Upon completion of the special care home guidelines video series — which actually was being taped today — currently being developed by the ministry, the region will develop a plan for long-term care staff to view this series.

On page 245, recommendation no. 6, we recommend that Heartland ". . . use a multi-disciplinary approach . . . [including] physicians, nurses, pharmacists for finalizing medical plans for long-term care residents," the region has developed a policy and procedure outlining its approach to medication management for long-term care. The policy includes a medication plan, a multidisciplinary approach to medication management, and the identification of high-risk medications. The region will communicate its new medication management policy and procedures as well as audit results to all stakeholders, clients, families, staff, physicians, and pharmacists in the fall of 2015. By November 30th, 2015, the region will clarify with the Saskatchewan College of Pharmacists the role of the community pharmacist as it relates to long-term care practice and will determine a process for multidisciplinary medication review on medication plans prior to dispensing.

The seventh recommendation on page 245, we recommend that Heartland ". . . establish standardized documentation requirements for medication plans of its long-term care residents," the region has developed a policy and procedure outlining its approach to medication management in long-term care. The policy includes a medication plan, a multidisciplinary approach. By November 30th the region will investigate other options for documenting additional information on the standardized medicine administration record for something like how to flag high-risk medications and to develop and standardize the documentation process.

Item no. 8 on page 246, we recommend that Heartland ". . . develop a policy for enhanced planning for long-term care residents with complex medication needs including the use of

appropriate assessment tools," the region will review and revise existing medication management policies and develop new policies as necessary by September 30, 2015.

By November 30, 2015, Heartland will investigate other options for documenting additional information on the standardized medicine administration record, as I mentioned earlier, and key information was given to staff following the release of the auditor's report. And again in August 2015, information included reminders for following established processes and policies.

On page 247, the 9th recommendation, we recommend that Heartland ". . . require that all appropriate approvals and informed consent for residents' medication plans are received from the long-term care residents or [their] designated decision makers," by October 31st the region will formalize medication planning documentation process, confirm client family involvement and consent in relation to medication plans and medication changes.

[15:45]

Recommendation no. 10 on page 248, we recommend that Heartland ". . . follow its policy for documenting, in the long-term care residents' medical records, all the medication-related activities," the region will continue to work with staff to ensure compliance with its existing policy and procedures and professional practice standards related to this documentation. Staff have been reminded of the proper processes for documentation with sharing of the auditor's report and focused information in the form of memos.

Additionally, clinical educators will continue to work with staff on documentation during site visits and scheduled education sessions. And following baseline chart audits, local and ongoing chart audits will guide improvement plans. They expect to have this recommendation implemented and completed by March 31st, 2016.

Recommendation no. 11 on page 250, we recommend that Heartland ". . . follow its established policies and procedures for medication changes for its long-term care residents," the region will review and revise existing medication management policies and develop new policies as necessary by September 30th. An audit tool has been developed to obtain baseline information, which I've talked about, and that audit tool will be in place by November 30th, 2015.

Item no. 12 on page 250, we recommend that Heartland ". . . implement a policy requiring informed written consent from long-term care residents or their designated decision makers for changes in high-risk medication."

So these would be one on the START/STOPP list or the Beers list. By October 2015 the region will develop a policy requiring written consent in high-risk medication and formalizing medication planning documentation process to confirm client family involvement, consent in relation to medication plans and medication changes.

Item no. 13 on page 251, we recommend that Heartland ". . . follow its policy to obtain informed written consent from long-term care residents or their designated decision makers before using medication as a restraint," key information was given to staff following the release of the auditor's report and again in 2015. Information included reminders for establishing or for following established processes, policies, and procedures including the restraint use process and behavioural assessments.

The current least restraint policy and procedure does require a process of assessment, trialling alternatives, involvement of the family, as well as written consent prior to chemical restraint use. Clinical nurse educators will provide public education to all care staff in the fall of 2015 and will include a review of the updated least restraint policy and procedure specifically highlighting the restraint use process and the need for consent.

Recommendation 14 on page 251, we recommend that Heartland ". . . consistently collect and document transfer information for residents transferred to its long-term care facilities," the region's client care coordinator collects client information upon entry into continuing care. All clients are assessed using the MDS home care, and the information is shared with facilities prior to the client moving into a long-term care facility. Additionally, the nursing information system of Saskatchewan transfer form is used to transfer information between long-term care facilities, and the whole chart is transferred electronically within the care organizer system. As well medication reconciliation is performed using the standardized Saskatchewan discharge transfer medication reconciliation form or the WinForms discharge medication reconciliation form when clients move from acute to long-term care.

Key information was given to staff following the auditor's report. The region will ensure that all sites are auditing data submissions and will monitor improvements. So the region feels that it is now complying with the auditor's recommendation on this one recommendation, and so the auditor in their follow-up will verify that with the region.

No. 15 on page 252, we recommend that Heartland ". . . track for analysis and reporting, all information on the prevalence of medication use and medication errors in its long-term care facilities." As I mentioned, the region's current policy and procedure on incident reporting has a process for informing both client and family practitioners when a medication error occurs. The quality department is reviewing its policies and procedures for incident reporting as well as its processes for tracking and reporting medication errors to facilitate analysis by November 30th, 2015, and the region has developed a baseline audit, or an audit tool for baseline data that identifies trends, needs, and issues related to medication management.

No. 16 on page 253, we recommend that Heartland ". . . follow its policy to have staff report moderate to serious complaints relating to long-term care to the Quality Improvement and Safety Department," the region has distributed revised client family handbooks to all client care coordinators in all 14 long-term care facilities. Revisions in the handbook include information on medication approach and the concern-handling process. The quality department tracks any documented concerns and initiates follow-up as necessary for a particular concern. By November 30th, 2015, the quality and concerns department will complete its review of policies and procedures

that are related to concern handling. As well, via letter, the region has informed current clients and families of the region's medication approach and a process for communication.

And last, no. 17 on page 254, we recommend that Heartland ". . . collect and analyze information to improve medication plans for long-term care residents," again key information was given to staff following the auditor's report and again in August 2015. It included reminders on the policies and processes and procedures of the region. By November 30th, 2015, the region will develop a plan for ongoing audits regarding medication plans for the long-term care residents.

The Chair: — Thank you, Mr. Hendricks, for a very thorough accounting of those recommendations. I'd like to open up the floor for questions. Mr. Marchuk.

Mr. Marchuk: — Thanks, Madam Chair. Just referring back to your colleague before you appeared, how does one define moderate or serious concern? Because what's moderate in one person's eye is not in another. And so I see you using that here as well.

Mr. Hendricks: — So I think that, you know, obviously as a health care system, one of the things that we've taken upon ourselves is to be very transparent and report critical incidents. And you know, Greg works with Accreditation Canada and visits hospitals and institutions across Canada and looks at their processes on things like medication reconciliation. And when I look at our critical incidents, this is one of the leading causes of harm and/or death to patients. And so it is a very serious issue.

But you know, in long-term care, not only in terms of the risk of harm but also the quality of life, you know, if people are not having their medications managed appropriately or if they're on an anti-psychotropic drug when they don't need to be, that severely affects their life. And so yes, it's a very serious issue and, you know, I think one that our regions take seriously. And I'm actually glad we're shining a spotlight on it, you know, because the only way that you actually can fix a problem is if it's transparent to you.

Mr. Marchuk: — Yes, I agree with all of that. I'm just wondering how moderate, mid-moderate is defined by each health authority, or how is that kind of standardized to use those words.

Mr. Hendricks: — I don't know that there's a standard. Again it's probably a good point, you know, in terms of that. I don't know if you have any . . .

Mr. Cummings: — All medication incidents would be taken very seriously, not only if the incident actually occurs but if there's a near miss, an opportunity for a mistake to happen. And when one of these is reported to us, an incident report is expected to be completed on it. And part of that process is to classify the incident in terms of level 1, 2, 3, 4, 5. And what that does is determine the level of intervention that's required afterwards, whether or not you would, for example, do a root cause analysis, which was mentioned earlier this afternoon, or whether the matter could be dealt with right there at the bedside at the time that it occurred with no further follow-up required.

Mr. Marchuk: — Does an incident have to be reported in writing before it's investigated? Because that's what I'm sort of gleaning from this.

Mr. Cummings: — Well our requirement would be that any potential medication incident or any actual occurrence, yes, there is a requirement to report that.

Mr. Marchuk: — So does this only apply to medications, or does it apply to other patient concerns that they may have regarding care?

Mr. Cummings: — It applies to any unusual occurrence that happens in a long-term care facility.

Mr. Marchuk: — Okay. So then I go back to, does it have to be in writing before it's investigated?

Mr. Cummings: — I would say, you know, depending on the nature of the incident. A lot of times when an incident occurs — say, for example, a fall — it's necessary to intervene immediately. So no, we wouldn't . . . Ultimately it would need to be documented. But the importance of the documentation, which I think is kind of a theme in this audit, that we don't do a good job of or we were found to not be doing a good job of the documenting, is to ensure that there's follow through and also the opportunity to collect data and learn from aggregate data what the themes are in terms of what we're doing well and what we're not doing so well.

Mr. Marchuk: — Okay, thanks.

The Chair: — Thank you. Mr. Wotherspoon.

Mr. Wotherspoon: — Thanks for all the information. Thank you for the work on the important recommendations. Just a few questions. The auditor's called for the comprehensive ministry's policies around medication to be aligned with the region's policies around long-term care facilities. And I know there's a date set that's nearing here, September 30th, 2015. And you may have mentioned this already, but will the region meet that deadline?

Mr. Cummings: — Yes we do. We were actually already in compliance with . . . We did have some of the policies in place in terms of our own regional policies. But what we need to do is the comparison with the requirements of the ministry and ensure that where we don't have a policy in place, that that's created. And that work has been done, so we expect that we'll be in compliance by the end of September.

Mr. Wotherspoon: — And then what about the actual . . . So the policy will be set. What about the implementation of that policy?

Mr. Cummings: — You'll notice that when we were reporting on the other recommendations, there's quite a rigorous education program required here. And some of that is providing new educational opportunities to our staff to ensure that they know what's expected of them. Some of it is reminding them of their professional obligations because it is part of what's required of them, for example as a registered nurse or as a physician or as a pharmacist. So there will be quite an extensive

implementation plan.

And also when we talk about quality improvement, particularly in this type of area, we call it continuous quality improvement because there's an ongoing need to do this kind of education and refreshing.

The other thing I would mention is that Heartland's a very rural health region and very geographically dispersed small communities. So one of the challenges that we have is that we create what it is that we know that we have to do centrally, and then we have to ensure that we get to all of those facilities in a large geographical region. So it'll be a lot of work, and probably by the time we finish the first round, we'll be starting a second round.

Mr. Wotherspoon: — I appreciate the piece around education and the region, some of the challenges as well. Do you have an idea as to . . . And I recognize that there's continuity to the education on these fronts. But as far as effective implementation from the perspective of the region, do you have a timeline as to when you'll feel that the new policy will have been effectively implemented?

Mr. Cummings: — Well I think that we would probably have a comfort level that we will have gotten the education complete and then gotten back to evaluate, you know, how good the uptake has been by the end of the year, being March 31.

Mr. Hendricks: — Can I just add one thing?

Mr. Wotherspoon: — Sure.

Mr. Hendricks: — An important element of this too, beyond education, is actually auditing and making sure that the information that we need recorded is actually recorded on a continuous basis. You know, you wouldn't want a pilot to skip the checklist occasionally. And I think that is the same here, is that we actually want our health providers to . . . This has just become such standard work that they're doing all the time, and it becomes, you know, something that you don't waver from.

Mr. Wotherspoon: — As it relates to the new audit system that you have, the new tracking system that you're developing, I understand that it'll be reviewing different categories such as potentially inappropriate medication use. Do you know at this point in time, or do you have information that you could share as to the estimate of how many people fall into this category right now? And then secondly, if you could break out the proportion that would fall into long-term care.

[16:00]

Mr. Hendricks: — Actually, I think the auditor actually reported some work. I would just check with Kimberly on the number of people that were on medications that had been identified as inappropriate on the Beers or START/STOPP list. And you know, that again would be a case where, for example, a person is on an anti-psychotropic without a diagnosis that would indicate that.

I can give you the exact figure unless you . . . just to give you an idea. And I don't know exactly what the auditor found. I just haven't been able to skim through this fast enough. And in your particular audit, I don't . . .

Ms. Ferguson: — I think you're referring to the information that we have on page 240 where we found that for the testing that we did, 66.7 per cent of the files that we looked at indicated the residents received three or more potentially inappropriate medications. So the incident rate in our sample we felt was really quite high in that area.

Mr. Hendricks: — And that number stuck out to me too from reading it. You know, provincially we do measure the number of people that are on anti-psychotropic drugs where they don't have a diagnosis of psychosis, and it is about 28 per cent provincially. And we do that quarterly. But it goes back to some of the auditor's recommendations is, you know, occasionally we're using chemical restraints as opposed to physical restraints. You know, there might be times when that's appropriate with a discussion with the family and the potential harm to the patient.

But I think our belief is that we need to do, as I talked about earlier, more education — you know, the gentle persuasion approach — in teaching our health care providers how better to deal with patients with complex issues so that anti-psychotropic drugs isn't the first line of defence. And I think that's what the auditor has also identified is that, you know, these measures have to be kind of a last resort after you've gone through all of the alternatives.

Mr. Wotherspoon: — I guess just the question was just the actual numbers, the tracking system that you're building and the numbers of the incidents I guess within this region that you would find as it relates to — what's the category? — potentially inappropriate medication use.

Mr. Hendricks: — The auditor found on their review of the files that 66 per cent of the patients were on a drug that appeared to be on one of those lists, the START/STOPP or the Beers list I think, as potentially dangerous drugs. But those are things that we should chart regularly, right, and, you know, as part of the patient's medication review which should be undertaken at a minimum when there has been a change in the patient's or resident's condition or on a quarterly basis. You know, the pharmacist, the multidisciplinary team, the RN [registered nurse], the doctor should be looking and if one of those drugs that appears on any of those lists which we publish in our guidelines, right — you know, these are the drugs you have to watch out for, right, because they're potentially dangerous — if they're on one of those drugs, there should be a good explanation and discussion of that.

Mr. Wotherspoon: — So do you have . . . Is the information available? I believe the regions developed a system, as I understood, to track this and other pieces. And so I think that's part of what's been reported out by work of the region. And I believe part of the category that's being tracked is the potentially inappropriate medication use, and I definitely appreciate some of the background that's being provided and also the response then that, you know, that is provided in those circumstances.

But in that tracking, do you keep track of the number of patients

then? The auditor has a number in her sample that they studied. In your tracking system, do you have the number of people who have, I guess — what's the word? — that may have potentially inappropriate medication use?

Mr. Hendricks: — So I understand your question now. So in the . . . You know, the auditor identified the need to actually track this information. And so this would require actually, you know . . . And I think Heartland's committed to doing that, you know, on these quarterly reviews, reporting out to within the home and to senior management the number of people that they do find that are on inappropriate medications. You know, as I mentioned earlier, one of the things is we've got to actually gather this information and put it in a place where it's visible if we're going to change these trends. I think we could easily check with our other regions to see what they have in place in terms of this.

It's supposed to be part of the MDS where you're actually going and looking at the care plan and such. So I'm just not sure how that's . . . you know, exists across all regions. But the auditor makes a good point, that her recommendations in the case of this report should be viewed by other regions and their processes should . . . You know, Heartland has been the example here, but their processes should align with these.

Mr. Wotherspoon: — Right. Without a doubt, I think some best practice is probably learning from this audit that would be . . . you know, would lend itself to other regions. Does the system right now that's been built by the region, that's I believe capturing this information, is that information now being captured or has it been captured?

Mr. Cummings: — The audit tool has been developed, you know, so that we've identified the criteria that we would want to focus on. And the data, it's possible to collect the data. And that's the next step is to begin to collect the data in an organized way so that we can analyze and make decisions based on what we're seeing.

Mr. Wotherspoon: — So right now, that data hasn't yet been collected for that category? That's why there's not a sort of . . . Like the question is just simply how many patients, you know, fall into that category right now in that region. You don't have that data collected yet, at this point in time. Is that correct?

Mr. Cummings: — I think one of the challenges that has been pointed out here with the audit is that we have not been doing that in an organized way even though the data is there. And so the work that we've done is to create the audit tool that we will use to do the collection and to actually analyze the data that we collect so that we can make decisions in that way, based on that.

Mr. Wotherspoon: — So from the data you have right now, would you have the ability to determine how many patients fall into the category of potentially inappropriate medication use?

Mr. Cummings: — Yes, I believe that we do have that ability. I don't have that data with me.

Mr. Wotherspoon: — Okay. Sure.

Mr. Cummings: — Yes, I believe that we would have the ability to do that.

Mr. Hendricks: — So just one other piece of information. Under *The Regional Health Services Act*, all special care homes and other designated facilities providing long-term care, as I noted earlier, are required to follow the guidelines for special care homes.

In 2014 a multidisciplinary medication review audit tool was added to the guidelines. It requires special care homes to conduct quarterly random audits on 10 per cent of the residents of the facility — so that would include their medications — so that we would actually have those kinds . . . but a sampling no different than the auditor uses to see if they're, you know, if they're compliant with that requirement. And we, as I said, we do outline those medications in our guidelines as well.

Mr. Wotherspoon: — Okay. So just as far as the analysis of the data then, or even the hard data itself that you've collected, it may not be readily available at the table here today. But would it be fair to request of you to endeavour to provide back to members of the committee the number of patients who would fall into that category of being potentially in the inappropriate medication use? And then breaking that out, what proportion of those patients would be in long-term care?

Mr. Cummings: — Yes, I think it would be possible to do that. Yes. It'd be a question of the process that we'd have to go through to collect the data, whether it would be some kind of a manual . . .

Mr. Hendricks: — Yes, at the end of the . . . You know, this is going to get easier as they do their quarterly chart reviews and record it and bring it up towards management to identify like, you know, I think you can use some . . . You can extrapolate if the auditor found 66 per cent of the region's 400-and-some residents had some sort of issue based on a sample of, you know, whatever . . . [inaudible interjection] . . . Seven per cent. You know, I don't know if that's statistically accurate to extrapolate or not, but I think we can get that.

Mr. Wotherspoon: — Yes, so if you have the actual data or if you have, you know . . . There's this sampling that, you know, seems to be quite high, seems to be concerning. So I guess if you're comfortable with that estimate then being applied to, you know, that becoming an estimate based on that proportion to a broader sampling.

So just maybe just a little more analysis, you know, on those numbers, and then to the best of your ability . . . If you have the actuals, great; if you're able to provide, you know, an estimate that you're comfortable with based on either your sampling or the auditor's, that would be helpful as well.

Mr. Hendricks: — I would just want to be sure that it's not one or two homes . . .

Mr. Wotherspoon: — Right.

Mr. Hendricks: — Versus all 14 homes in the region or . . .

Mr. Wotherspoon: — And I want to be careful too not to simply take the 60 per cent number, which seems large, and just

apply it across the piece. But I'd appreciate that.

The other, the region tracks medication errors, I understand, and for all code 3 and 4 incidents an investigation occurs, is my understanding. I'd be interested in knowing if you have the actual number or an estimate of the number of investigations that are completed annually, and what sort of trends there might be in the results of those investigations.

Mr. Cummings: — Related to medication incidents?

Mr. Wotherspoon: — Right. I understand that there's a code 3 and 4 of medication incidents that then require an investigation. So I'd be interested to know how many investigations were initiated, thus I guess how many code 3 and 4 incidents there have been. And then what sort of trends have been found or what sort of factors have been found? What sort of information's been found in these investigations?

Mr. Hendricks: — The ministry can provide that or that I can provide that to the committee.

Mr. Wotherspoon: — Not readily here.

Mr. Hendricks: — Yes.

Mr. Wotherspoon: — Okay. Well I appreciate in due course that information coming back. Thank you very much.

The Chair: — Are there any further questions on this chapter? Mr. Michelson.

Mr. Michelson: — Just, you know, there's a lot in this particular chapter. You're doing a lot in that health region. But I just was wondering, and it was kind of alluded to before, is there communication with the other regions to put this all together and to have like programs throughout? I think that's very important.

Mr. Hendricks: — So on patient safety issues, what we actually do is we do system-wide visibility walls where myself, with the CEOs of the health regions and the board Chairs, do a wall walk every quarter where, you know, patient safety measures like medication reconciliation compliance are measured and out there.

And also we do the critical incident reporting. So we know in great detail the number of critical incidents and what was actually done as a follow-up to those critical incidents when there is a medication error.

One of the things that we have introduced recently is that — well not recently; it's been about a year or so now or a year and a half — is that every second week I do a call with my CEOs and at that point the CEOs . . . Or every two weeks a different CEO presents a critical incident and what they have done to actually correct that, their learnings from it. So we are getting better as a system. It's spreading those learnings. We also put information in terms of, you know, when there is a safety issue that has been identified in the health care system, that's fanned out to all the quality care coordinators in the regions and to regional staff so that if a safety issue exists in one region, it might exist in another. So we want to make sure. You know, it's kind of like a recall almost, you know. So we do do that as well.

Mr. Michelson: — Thank you.

The Chair: — Are there any further questions? I have one actually and it's more of just in thinking of some of the discussion that we've had here this afternoon. I'm looking specifically at recommendation no. 5 and our update where the comment about gentle persuasion being used. Obviously gentle persuasion is really an important tool for all continuing care aids and health care workers to be able to use. But I think that . . . And obviously this reporting and documenting and the processes I think are really great. And Heartland, you guys have undertaken some really good work to resolve some of your issues. And I hope that it'll be used province wide because the numbers that you've cited, Mr. Hendricks, province wide aren't great. Either you said 27 per cent . . . [inaudible interjection] . . . 28 per cent of not the proper medication or without a proper diagnosis.

But I think that the elephant in the room for me is when you've got gentle persuasion, you need, as a staff person, you need the time to be able to use gentle persuasion. And anecdotally and through the CEO reports and through the Ombudsman's report, I mean we see an issue of lack of staff in many of our long-term care facilities. I think many people who work in these facilities . . . I don't know if chemical restraints is the path of least resistance but when you're stretched thin and you're dealing with patients who require much more time, sometimes you do the things that many of those residents' families wouldn't like. So I think for me, the elephant in the room is staffing. I mean it's great to put in the processes and track, and maybe by tracking some of this you'll be able to make a case for needing more staffing even. If you've recorded all this information, I think more data allows you the opportunity to say, we need more resources.

But I think for me the big issue is, or the elephant in the room is staffing in some of our long-term care facilities, and why staff are feeling the need to use chemical restraints. I don't know if you've got any thoughts on that, Mr. Hendricks.

Mr. Hendricks: — You know, as the auditor said, to use chemical restraints, you know, there needs to be a consultation with the physician, with the family and with the whole care team to make sure that that's appropriate and all other avenues have been exhausted.

You know, when I think about some of the challenges that we're facing in long-term care, I don't exclude the possibility that in some long-term care homes, you know, staffing is a challenge. And people, you know, I know a lot of people in our health care system work very hard and they're very committed to providing the best care to what is a very vulnerable segment of our population. But in an early, you know, in some of our earlier discussions, one of the things that we have to do is make sure that our providers in long-term care are actually focused on doing the right things and that certain tasks — administration, paperwork, that sort of thing — aren't taking them away from their primary duty of providing primary care.

So it's striking the balance about the need to measure, to document, do all of that with what their primary role is. And we

also need to be sure that, you know, we're empowering providers to do and to make care decisions, you know, and to provide the best care, and that we actually are using people to their scope in long-term care homes.

So it's a multifactorial thing and, you know, I know that it's really easy to say staffing, and I don't exclude it in all situations. But I really need to understand the full picture because I've seen situations where we've added staff because that seemed like the easiest thing and it hasn't made the difference because if there are other distractions or if the culture is not good or something, then there aren't very many changes.

So it might be the answer in certain situations but, you know, we need to understand. And that's one of the things that I think as a ministry, and my minister said, we are committed to do. We're committed to understanding through our various, you know, measuring and that sort of thing as a system to improving senior care and looking at how we can better monitor it.

The Chair: — And I appreciate that there's not a simple . . . There's many, many factors that come into play, but I know in my role as the Health critic and over and over and over again I hear about ratios of two CCAs [continuing care assistant] at night for 55 residents with one nursing staff. Like those kinds of things. But I think for me, as I said, I think these recommendations are good and I think that documenting always is absolutely critical. But I think about our conversation about root causes and, like a root cause analysis, why we would be using chemical restraints is something to consider.

Mr. Hendricks: — Maybe can I just respond to the one comment about the two CCAs for X number of staff? You know, we hear those examples. You know, nobody I think in administration and certainly myself in the health care system wants to see staff-to-patient ratios that are completely stretched, but that's not always . . . The situation there is not always that they're not being staffed appropriately. The reality is that sometimes people phone in sick and you can't get a replacement. You know, we go through call lists and call lists. You know, the other day we were having a good discussion with one of our stakeholder groups about premium time and, you know, we have a large casual workforce that's meant to fill in on short notice for absences, and oftentimes you can't access them.

So in some of those cases we just need to be careful that it's not for a lack of trying that we can't have the ideal ratio or we can't find anybody. And it's particularly challenging in some of Greg's smaller communities where there's a smaller labour pool to draw from.

The Chair: — For sure. And the 2 to 55 is a regular ratio at night. That didn't happen once with a few people sick. But I think again that goes back to that root cause discussion: why, when you've got a large casual staff, why people are calling in sick, why people are on disability, why you can't staff, why people aren't wanting to come to work. So I think again that goes back to asking that root cause. Why is that happening? And obviously in rural Saskatchewan there are some challenges that there aren't in a centre where I live, but we see it throughout the province.

Mr. Hendricks: — And we have engaged our provider unions in that discussion. I think it's probably the first time that the ministry and the RHAs are working directly with unions to try and look at some of those root causes and see if the unions, you know, from their perspective and from their members' perspective, are willing to engage in strategies to address that. And I think that's the most positive work the system can be undertaking, you know, or some of the most positive work.

The Chair: — Well thank you for that and thank you for your comments. We've got 17 recommendations with which we need to deal here. I'm wondering if I could have . . . Are there any further questions on any of these recommendations? Seeing none, Mr. Doke.

Mr. Doke: — Madam Chair, in regards to the 2014 Provincial Auditor report volume 2, chapter 35, recommendations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, we would concur with the recommendations and note progress towards compliance.

The Chair: — Thank you, Mr. Doke. Mr. Doke has, for the 2014 Provincial Auditor report volume 2, chapter 35, moved that this committee concur with the following recommendations: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17. Can we concur with the recommendations and note progress to compliance? Is there any further discussion on these? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Mr. Doke.

Mr. Doke: — Well thank you, Madam Chair. In regards to the 2014 Provincial Auditor report volume 2, chapter 35 with recommendation 14, we would concur with the recommendation and note compliance.

The Chair: — Thank you. Mr. Doke has moved that, for the 2014 Provincial Auditor report volume 2, chapter 35, that this committee concur with recommendation no. 14 and note compliance. Is there any further discussion on this? Seeing none, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Thank you. Mr. Hendricks, would you like to make any final comments, or Mr. Cummings?

Mr. Hendricks: — Well I would just like to thank the Provincial Auditor and her office. We have a very good working relationship with her deputies, principals, and staff that work in our region and our RHAs every day, and we do appreciate valuable insight. It's always good to have, you know, an outside person come in and look at how things are running within a system. I'd also like to thank the committee members for the opportunity to go through these recommendations today, so thank you very much.

The Chair: — Thank you very much for your time today. We really appreciate that. With that, the committee stands . . . Oh I need an adjournment. It's been a long day. Mr. Norris.

Mr. Norris: — I offer that motion of adjournment.

The Chair: — Okay. Mr. Norris has offered a motion of adjournment. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay. This committee stands adjourned until the call of the Chair.

[The committee adjourned at 16:25.]