Office of the Auditor General / Bureau du vérificateur general

AUDIT OF THE LONG TERM CARE BRANCH

2008

VÉRIFICATION DE LA DIRECTION DES SOINS DE LONGUE DURÉE

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EXECUTIVE SUMMARY

Introduction

The Audit of the Long Term Care Branch was included in the 2008 Audit Plan of the Office of the Auditor General, first presented to Council in May 2005.

Background

At the time of this audit, the Long Term Care (LTC) Branch was part of the Community and Protective Services Department (CPS) and reported to the Deputy City Manager. The Branch consisted of four long term care homes each with an Administrator reporting to the Director of Long Term Care. In late 2008, the LTC Branch was dissolved and each home administrator now reports to the General Manager, Social Services. As the audit was conducted prior to this re-organization, the report reflects the previous administrative structure.

The homes receive support from the administrative arm of the Branch as well as from the Centres of Excellence (COEs). The COEs consist of the Financial Support Unit (FSU), Real Property Asset Management (RPAM) and Employee Services including Health and Safety.

Until the new Long Term Care Homes Act (2007) receives Royal Ascent, the City's homes continue to operate under the *Homes for the Aged and Rest Homes Act* (the Act) and service agreements with the Ministry of Health and Long Term Care (MOHLTC).

The Act also sets out a fundamental principle that represents a key consideration for this audit; that is, that the residents residing in the City homes receive quality care and services that meets their needs. This principle, as defined in subsection 1.1(1) of the Act states:

> *"The fundamental principle to be applied in the interpretation of this Act, the regulations and a service agreement relating to a home is that a home is primarily the home of its residents and, as such, it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."*

Under the terms of the service agreement between the City homes and MOHLTC, the City agrees to operate the homes within the legislative provisions of the Act. The degree to which the homes' operations are compliant under the Act is determined through the annual compliance review program undertaken by Compliance Advisors of the MOHLTC Performance Improvement and Compliance

Branch. The homes also participate in the voluntary evaluation conducted by the Canadian Council on Health Services Accreditation.

In total, the Branch operates 711 beds across its four homes, thus representing 15% of the total 4,694 long term care beds operating in the City of Ottawa. The four homes are geographically distributed across Ottawa and each exemplifies unique characteristics, services and organizational cultures.

LTC Home	Number of Beds	Location	Opening Date of New or Renovated Building	MOHLTC Structural Compliance	Unique Characteristics
Carleton Lodge (CL)	160	Nepean	1989	A	On-Site ADP
Centre d'accueil Champlain (CAC)	160	Vanier	1998	A	On-Site ADP Francophone
Garry J. Armstrong (GJA)	180	Central Ottawa	2005	A	Bilingual
Peter D. Clark Centre (PDC)	211	Centrepointe	2001	A	Bungalows
Total Municipal Beds	711				

The 2007 budget for Branch operations was $46.3 million with a net levy requirement of $8.1 million exclusive of debentures.

Audit Objectives

As an audit, this assignment involved the following three components: compliance, value-for-money and financial statements with the primary focus being on the performance (value-for-money) component. The value-for-money component of an audit is intended to assess the adequacy of management systems, controls and practices including those intended to control and safeguard assets to ensure due regard to economy, efficiency and effectiveness. Further, the effectiveness of the programs and services is a key element to these types of audits. With respect to the auditing for compliance with legislative and related authorities, the intent is to express an opinion on whether the entity complied with specific legislative requirements and specific authorities.

As this is an audit in a public sector organization, Public Sector Accounting Board (PSAB) accounting and auditing standards apply (i.e., PS 5300 Auditing for Compliance with Legislative and Related Authorities in the Public Sector, PS 5400 Value-for-Money Auditing in the Public Sector). The auditors also followed the practices as recommended by the Canadian Comprehensive Auditing Foundation with respect to comprehensive and value-for-money auditing.

Audit Scope

The scope of this audit encompassed the four long term care homes operated by the City of Ottawa's LTC Branch. Due to the structure of the Branch and the financial services, this audit required significant analysis and interaction with the FSU assigned to LTC and Public Health as well as other COEs. The audit was comprised of three components including compliance, financial and performance (value-for-money) with the weight of the investigation focused on the latter component. Although data and information was available for the fiscal years from 2001 to 2007, the audit focused on the two fiscal years, 2006 and 2007.

In addition to the three audit areas described above, this report presents a summary of the analysis conducted in 2001 by the former Audit and Consulting Services Branch regarding potential alternate service delivery options for Long Term Care.

Summary of Key Findings

General

1. Overall, the observations of the audit indicated that the LTC Branch and the homes are providing quality care and services to the residents living in the City homes. Residents are well cared for as are the buildings in which they live. The high levels of customer satisfaction reinforce this favourable audit finding. The homes present a comfortable and safe living environment which provide myriad opportunities and supports for residents to experience good quality of life. There are many new and evolving operational and clinical initiatives that speak to the homes' commitment to best practices and quality improvement. The homes value relationships with and amongst the resident population, families, friends and staff.
2. The City supplements the operations with tax levy over MOHLTC level of care and envelope funding. This is typical among municipal homes across the Province. The financial constraints experienced by all municipalities including the City have necessitated a greater emphasis on cost reduction and enhanced operational efficiencies. While the City homes have engaged in these efforts to some degree, further opportunities may exist. These cost saving efforts will also require longer range planning as the relatively new buildings and their systems continue to age.
3. There are several key projects currently underway that will assist in the ongoing improvement of operational effectiveness and efficiency, and that may potentially increase revenue opportunities as well. In particular, the implementation of Goldcare (i.e., resident care documentation system) and Telestaff (i.e., staff scheduling system) both have the potential to enhance the effectiveness of documentation and the efficiency of staff.

4. Although the COEs provide good service to the LTC Branch and the homes, the significant segregation of duties between these units and homes has an impact on the effectiveness of the operations. There are consequences for accountability at the management levels of the Branch and the homes. This is particularly evident in financial accountabilities for budgets, trust accounts and accommodation billings. Financial reporting is undertaken at a very high level and managers have had to develop their own systems to assist them in making decisions. Although SAP, the City's financial system, is considered state of the art in the industry, it does not provide some of the information required by long term care.

Compliance

1. The MOHLTC compliance reports illustrate few unmet standards (e.g., mandatory in-service training sessions on an annual basis for 100% of staff and Food Service Worker Certification) and thereby suggest that the homes are diligent in their efforts to operate as per the policies, standards and legislation governing long term care operations. In some instances, certain homes have been particularly responsive to prior compliance issues and have recently realized more favourable reports. It is, however, unusual in an organization with multiple LTC sites that compliance plans are not forwarded to a central authority or other designate for review vis-à-vis consistency in approaches and commitments prior to submission to MOHLTC.
2. Policies and procedures are comprehensive and generally understood by managers and staff. There is, however, the opportunity, as part of the ongoing policy development and review process, to further refine the organization and structure of the manuals.
3. There are some inconsistencies in the implementation and adherence to policies at the home level. Furthermore, there is limited standardization in documentation practices across the homes. There are also some inconsistencies of understanding of the change process for policies and procedures.
4. The Branch relies heavily on the Employee Health and Wellness for occupational health and safety advice. There is an opportunity to review and update the organization and structure of the health and safety policies as well as to review these policies against the Health Care Regulations. Furthermore, the terms of reference for the Joint Health and Safety Committee contain a provision with respect to workplace inspections that are contrary to the intended provisions of the Occupational Health and Safety Act.
5. The training requirements and the Staff Training Policy do not fully satisfy the mandatory training expectations of the MOHLTC. The target for staff participation in training is set well below 100% of the staff complement. Furthermore, there is no comprehensive training manual complete with learning

objectives for each mandatory training topic, thus limiting the effectiveness of the training evaluation efforts.

6. Purchasing policies and practices are not followed in a consistent or congruent manner. In addition, there is no inventory management system to ensure that items are allocated appropriately and costed to the appropriate cost centre. Inventory controls are such that management cannot be confident that assets are safeguarded.
7. Trust and accommodation accounting practices lack proper documentation and do not fully meet program standards set by the MOHLTC. There is minimal guidance for staff in the homes, and there is no thorough or consistent annual admission agreement reviewing/updating process.
8. With respect to accounts receivable, there is no policy in this regard. The policies are unwritten and informal. Consequently, it is possible that the City is not realizing its full revenue and investment potential.

Financial Management

1. The homes meet their requirement to provide a minimum of 40% of their respective beds at the basic accommodation rate. At the Branch level, as a collective, the homes are exceeding the requirements for basic accommodation. It is recognized that Garry J. Armstrong continues to be challenged to maximize its preferred revenues.
2. There is limited understanding of the eligible expenses by funding envelope as permitted by MOHLTC. As well, there was little to no knowledge of the impact that the move to full accrual accounting under PSAB may have on this reporting. The MOHLTC has yet to change these program standards in light of PSAB changes.
3. The implementation of Goldcare may present greater opportunity to enhance resident care documentation and as such may help the homes realize increases in their Case Mix Measure (CMM)/Case Mix Index (CMI). These increases will thus reflect in their level of care funding in the nursing and personal care envelope.
4. The resident business files lack sound organization, consistency and required documentation. There are charges to the resident trust accounts that do not have appropriate back-up or authorization. Staff in the homes lack information to determine whether or not a particular charge can be charged to the resident as they do not have access to this resident-specific information.
5. Budget guidelines and parameters for the long term care homes' budgets are provided by Corporate Finance. This practice leaves fewer opportunities for decision making to the Branch or to the individual homes. There are top-down

targets provided to the Branch to meet without an assessment of risk from both the resident care and building operation perspective.

6. There was little understanding within the LTC Branch or the FSU regarding PSAB or the new reporting standard.
7. Each home currently employs staff who provide services that ideally should represent full cost recovery (e.g., hairdresser). In a number of instances, these cost recoveries are not being realized and there may be an opportunity to assess these services vis-à-vis standard practices across the long term care industry.
8. With respect to meal recoveries, there are some issues specific to catering and meal sales. The Branch does track costs and recoveries. It is clear from their own reconciliation that these costs are not being covered. Although there is no expectation for full recovery, cash management processes are weak in this regard. As well, it was recognized by managers that they had not been charging for paper products in their costs.

Performance

1. There is a lack of staffing indicators to assess the effectiveness and efficiency of the Service Delivery Model.
2. The resident and family surveys indicate very high levels of satisfaction with the homes across all care and service domains. There are some noteworthy trends (i.e., falling family satisfaction results at one home) which are receiving the full attention of the management teams in the affected home.
3. The resident and family surveys are limited in scope with respect to financial considerations and services. Consequently, service levels may not be fully explored.
4. There is insufficient control over inventory and there is no analysis undertaken in order to analyze usage and potential leakage. The inventory management systems are weak and/or non-existent.
5. Technology implementations (Goldcare and Telestaff) are still in their infancy but are not being directed by sound project management practices.

Potential Alternate Service Delivery Options

An assessment of potential alternate service delivery options for LTC was not included in the audit plan for this audit. However, in 2001, management requested that the former Audit and Consulting Services Branch undertake an analysis of possible long term care service delivery models to ensure the City is maximizing potential savings and making the most effective use of tax dollars. It was felt it would be useful to provide a summary of this 2001 study to management and Council as part of this audit report for consideration.

Given the analysis undertaken in the 2001 review, in particular the legislative and collective agreement constraints, complete divestment of the City's long term care program is not a realistic option for the short-term. Council may wish to give more serious consideration to the other options, specifically, private-sector management contract, devolution to a not-for-profit organization or maintaining LTC as a direct City service.

Recommendation 1

That staffing statistics be available to managers at the homes so that they are readily able to confirm that standard requirements are being met (for example Food Service Worker Certification, annual renewal of registration for staff and CPR certification status etc.).

Management Response

Management agrees with this recommendation and it is current practice. Staffing statistics are currently available to managers via a request to administration to print a report from the LTC staff training and development database, as well as in the employee's personnel file. Information in the staff training and development database is scheduled for conversion to SAP in Q1 2009 and will continue to be accessible to administration staff, but will be available to managers at their desktops.

Recommendation 2

That the Branch review the MOHLTC standard for mandatory training, measure adherence and revise accordingly with the goal of meeting the expectation that 100% of staff are attending all annual mandatory training as defined by MOHLTC standards.

Management Response

Management agrees with this recommendation. However, it is important to note that there is a difference between mandatory training requirements of the Ministry of Health and Long Term Care and developmental training provided by the LTC branch.

In an effort to improve delivery and effectiveness of mandatory training programs, management has reviewed a training delivery model that would ensure 100% completion of training by all full-time, part-time and casual staff members. The estimated costs of this model are $195,000 for staff attendance and $90,000 for implementation. Funding for this model will be brought forward as an identified pressure in the LTC 2010 budget.

Recommendation 3

That the Branch develop a process by which the compliance plans are vetted centrally prior to submission for consistency and are accessible by the other

homes to allow all homes to be more proactive in ensuring that their home meets or exceeds compliance standards.

Management Response

Management agrees with this recommendation. The director of LTC currently reviews all compliance plans before submission to the MOHLTC. In addition, annual compliance plans are reviewed by the branch management team (which includes representation from all four of the City's homes) to identify policy, procedure and best practice implementation. The process will be documented to clarify for managers who may be non-compliant. The compliance plans are available centrally in the branch office. Electronic availability will be reviewed in Q2 2009.

Recommendation 4

That during the next round of policy reviews, a restructuring take place so it is easier for various levels of staff to find appropriate policies (for example, having discrete sections for resident information, trust accounting, human resources, etc.).

Management Response

Management agrees with this recommendation. LTC policies are currently divided into the following categories: food services, laundry, housekeeping, resident care, recreation and leisure, social work, medical, infection prevention and control, health and safety, emergency response and administration (home/office and branch).

Policies regarding trust accounting are maintained by the FSU. Human resources policies are corporate. All LTC and corporate policies are accessible to staff through Ozone. Also, all LTC policies are provided in print manuals located in designated areas at each home and in the branch office, which has been communicated at both general staff meetings and management meetings. The location of LTC-specific policies by service area will be reviewed as part of the three-year comprehensive cycle. The next cycle will begin in summer 2009. As part of this process, staff will review the policy and procedures manuals and associated indices from other LTC organizations of comparable size and structure.

Recommendation 5

That the Branch determine key locations for storage of policy manuals to ensure that staff have ready access to necessary information and a means to verify that they remain current.

Management Response

Management agrees with this recommendation. The branch office currently designates and maintains a list of the locations for policy and procedure manuals as indicated in the policy and procedure (reference no. 700:02 Policy and Procedure Manual) approved in November 2005 and revised in March 2006. The administrative assistants in each Home are responsible for replacing revised and new policies and procedures in each manual. In addition, all LTC branch policies and procedures have been accessible through Ozone since 2007. The location, both physical and electronic, of LTC-specific policies by service area will be reviewed as part of the three-year comprehensive cycle. The next cycle will begin in summer 2009.

Recommendation 6

That the Branch review its practices on home-specific policies to determine which policies and/or worksheets need to be home-specific and which are best to be Branch-driven to promote consistency.

Management Response

Management agrees with this recommendation. LTC has a policy and procedure regarding the development process for new policies and procedures (reference no. 700:02 Policy and Procedure Manual). All policies and procedures have a designated group for approval and any home-specific policies must be brought to the approving body for review and approval.

This level of consistency review may not have been clearly articulated in the policy and procedure document therefore, it has been modified to reflect a requirement for referral of home-specific policies and procedures to the branch management team for review and approval.

Recommendation 7

That the Branch's three year cycle for policy review include a work plan highlighting the policies to be reviewed and target dates.

Management Response

Management agrees with this recommendation. Work plans highlighting policy review target dates are coordinated by each functional team area, which maintains approval authority for the policies and procedures. LTC will review the centralization of these work plans in Q1 2009 and will include this requirement in the functional team terms of reference. In addition, a requirement to report on progress will be incorporated into quarterly LTC reporting requirements. As a result of this review, the branch may need to request funding in the next budget for a centralized FTE to fulfill this role.

Recommendation 8

That the Branch review its Health and Safety policies to align them with the Health Care Regulations in order to assist the Branch to respond more succinctly to a Ministry of Labour Inspection and ensure that it meets operating requirements.

Management Response

Management agrees with this recommendation. The Occupational Health and Safety division will assist LTC with a review of their health and safety policies by the end of Q2 2009, in an effort to better align them with Health Care Regulations.

Recommendation 9

That methods of communicating policy change be measured for effectiveness and that access to online policies for care staff be explored as an option to increase accessibility.

Management Response

Management agrees with this recommendation. Access to online policies and procedures has been in place since 2007. Effectiveness of the communication of policy changes is measured as part of the annual compliance review by the Ministry of Health and Long Term Care and in the LTC accreditation process that takes place every three years. An internal measurement tool will be reviewed and considered in Q3 2009.

Recommendation 10

That policy changes be discussed and minuted at appropriate committees on a consistent basis.

Management Response

Management agrees with this recommendation and it is current policy. As part of branch policy and procedure (reference no. 700:02 Policy and Procedure Manual) it is the responsibility of functional teams to consistently review and record policy changes. The terms of reference for functional teams was reviewed in Q1 2009 and the specific responsibility for policy and procedure review will be documented to improve consistency in practice.

Recommendation 11

That the Branch develop a consistent policy regarding meeting protocols and records retention practices, including a standard meeting agenda format, a minute template to be used for all meetings and a master schedule with the various committees planned on an annual basis and distributed for reference.

Management Response

Management agrees with this recommendation. To meet accreditation requirements there are terms of reference in place for all committees of the LTC branch. The last review was completed in 2007. LTC will review the use of master templates across the branch versus across homes in Q1 2009. LTC will consider the expansion of master home schedules to a master branch schedule. As a result of this review, the branch may need to request funding in the next budget for an FTE to fulfill this function.

Recommendation 12

That the Branch adopt the practice that has been employed at Champlain for the "Journal interne Soins infirmiers".

Management Response

Management disagrees with this recommendation. There are branch and home templates for staff, resident and family newsletters. The practice at Champlain represents a diversion from branch policy and a duplication of work. This practice represents an inconsistency in staff communication and the branch director would like to see it discontinued by Q4 2008. Elements of the Champlain newsletter will be incorporated into the templates. The required process will be documented as part of a long term care comprehensive communication program for staff.

Recommendation 13

That the Branch review its purchasing practices to ensure that appropriate segregation of duties, documentation and settlement processes are implemented.

Management Response

Management agrees with this recommendation. LTC and Financial Services have conducted a review of the branch's purchasing practices and have implemented appropriate segregation of duties or mitigating controls.

Recommendation 14

That the Branch review its use of procurement cards and approval processes to ensure compliance with the corporate Purchasing Policy, including requiring any cardholders who allow others to make charges to their card to provide the appropriate written authorization.

Management Response

Management agrees with this recommendation. As stated in the corporate purchasing card policy and procedures, cardholders shall not share their cards with other individuals unless their director has given written approval, in order to meet operational needs of the department. LTC is now in compliance with

this procedure as the management team have provided written authorization to the store person to place orders on their behalf. In order to minimize any additional future risks, the branch has implemented an internal policy whereby all orders placed by the store person will be processed against their purchasing card. The purchasing card is then reconciled and approved on a monthly basis by the store person's manager and Financial Services as outlined in the purchasing card procedures.

The Auditor General also noted in the audit report that items were purchased without competitive quotes. Competitive quotes were not required as the purchases were of an urgent nature and were of a small dollar value.

LTC implemented a cooperative purchasing process in 2007 through a consolidation of the request for tender process across the homes. Purchasing for medical supplies, food and environmental services is coordinated through standing offers.

Recommendation 15

That the City complete the procedures in the Managers Tool Kit and combine the various manuals into one key binder as well as update the Ozone intranet site.

Management Response

Management disagrees with this recommendation. The 'LTC Managers Tool Kit' was developed as an orientation tool for new managers in LTC. The toolkit is a reference manual, not a policy and procedure manual and refers managers to Ozone for various types of information. The toolkit is updated regularly, as new information becomes available via e-mails to managers. It is the individual responsibility of each manager to insert the revised information into their respective manual. This process will be reviewed and the reassignment of this task to the same responsibility centre for revisions to other policy and procedures manuals in each home will be considered. The toolkit has been shared at a departmental level. It is outside the scope of authority for the LTC branch to make this toolkit a corporate resource.

Recommendation 16

That a standardized work planning process be established across the Branch in order to roll up to the Branch-wide short and long term planning framework and that this process be developed in line with the City and CPS Department planning frameworks and include both a reporting as well as a communication strategy.

Management Response

Management agrees with this recommendation and this is current policy. LTC has used a balanced scorecard approach to work planning since 2005. Every year

LTC reviews corporate and departmental directions and priorities and incorporates these into branch-level planning. As an example, in 2008 LTC revised the balanced scorecard to reflect the City's direction toward service excellence and the departmental direction of customer service.

The LTC strategic planning and work plan development process, coupled with revision of performance measures is conducted as a collective every fall. This step is followed by the development of home-based work plans that reflect the major priorities of the LTC branch. LTC has a quarterly reporting process for the status of achievement on the branch work plan. This information is communicated at quarterly branch meetings and monthly general staff meetings. It is also communicated as an on-going component of the LTC accreditation process. The specific templates to be used will be added as supporting documentation to policy and procedure 700:34: Quality Management to increase consistency in the work plan templates.

Recommendation 17

That the Branch and FSU develop a consistent mechanism to analyze the gapping requirement against the Service Delivery Model and quality indicators such that the impact of the practice on residents can be assessed.

Management Response

Management agrees with this recommendation. A new corporate Vacancy Allowance policy has been approved by Executive Management Committee, which established a gapping rate of 1.6% per department. LTC, Financial Services and Human Resources will enhance current gapping reports to improve gap analysis so that quality indicators such as impact of the policy on service delivery can be assessed. This will be implemented by Q4 2009.

Recommendation 18

That the Branch and FSU develop a preferred accommodation policy and associated procedures to be shared with the Community Care Access Centre in order to provide clarity and an avenue for communication to continue to improve preferred revenue income.

Management Response

Management disagrees with this recommendation. LTC currently has policies and procedures in place to notify the Community Care Access Centre when bed vacancies arise. This policy has been shared with the CCAC to ensure that preferred accommodation is maximized. It requires that the type of accommodation available (preferred or basic) be identified at the time of notification.

LTC complies with regulation 39.0.1 under the Homes for the Aged and Rest Homes Act which states that, "a home shall ensure that no more than 60 per cent of the bed capacity of the home is set aside as preferred accommodation". Collectively, preferred accommodation revenue was at 96% for 2006, 97% for 2007 and is at 99% as of the end of August 2008.

Recommendation 19

That, as part of the implementation of Goldcare, the Branch and FSU develop new reports or views from Goldcare to provide electronic census reports including flags to assist the social workers with bed moves to maximize preferred accommodation revenues.

Management Response

Management agrees with this recommendation. New reports have been developed and implemented to assist social workers to ensure that preferred accommodation revenue, which is currently maximized, will continue to be so into the future.

Recommendation 20

That the Branch and the FSU confirm its knowledge of the eligible expenses in each envelope on a regular basis and analyze these costs on a vertical and horizontal basis (between homes, between years and externally to other homes).

Management Response

Management agrees with this recommendation. Both Financial Services and LTC staff are aware of and understand the eligibility of expenses within each funding envelope. Annual third party audits are performed on expenditures to ensure compliance with specified ministry guidelines. Increased reporting and analysis of expenses within the funding envelopes will be undertaken by the branch, in conjunction with Financial Services, and will be implemented by Q2 2009.

Recommendation 21

That the Branch develop a comprehensive project plan for the Goldcare implementation with key milestones and deliverables, including regular reporting on its status, results and training activities as well as specifying years to payback of the system.

Management Response

Management agrees with this recommendation and a project plan, developed by the branch, IT and the vendor is currently in place.

A project plan has been in place since the project started for ongoing implementation and development. A branch steering committee and user group were established post implementation (Q4 2008). These teams meet on a

quarterly and monthly basis as per their respective terms of reference to address emerging issues and to identify new opportunities as the software version upgrades are introduced. Status reports are provided as part of the standing agenda items to the branch management team.

Recommendation 22

That the Branch benchmark their Case Mix Measure prior to the implementation of Goldcare including the subsidy against post Goldcare implementation.

Management Response

Management agrees with this recommendation and it is current practice. The LTC branch has tracked the Case Mix Index and Case Mix Measure across the four homes for the past seven years and has continued to do so following the first phase of Goldcare implementation, which was completed in May 2008. This documentation is distributed to administrators and managers of Resident Care annually. Of note, is that as of Q4 2009 CMI will no longer be used to evaluate residents in LTC homes. This program conversion is in phase 6 of a provincial conversion to the Resident Assessment Instrument-Minimum Data Set (RAI-MDS). City homes will be participating in the provincial RAI-MDS program and will no longer receive CMI and CMM results.

Recommendation 23

That the Branch forward a copy of the High Intensity Needs claims to the FSU in order to improve accounts receivable practices and allow for proper reconciliation.

Management Response

Management agrees with this recommendation. A process for reconciliation of High Intensity Needs claims against Ministry revenue was developed and implemented as part of the first phase of Goldcare implementation, which was completed in May 2008.

Recommendation 24

That the Branch review the High Intensity Needs policy against internal practice to determine if there are additional cost recovery opportunities for the home.

Management Response

Management agrees with this recommendation. The branch conducts this practice on an annual basis to ensure all cost recovery opportunities are maximized. This practice will be documented in the Q1 2009 review of the terms of reference for the functional teams.

Recommendation 25

That the Branch coordinate grant program submissions and assist home management with the response.

Management Response

Management agrees with this recommendation and it is current practice. The ongoing practice is to coordinate grant submissions through the LTC branch management team. This practice was introduced in 2004 to maximize the homes' ability to access newly announced funds through the provincial nursing strategy. Upcoming funding opportunities are discussed at branch management team, an administrator is selected to coordinate the application on behalf of the branch and a central application is submitted. In some cases the Ministry of Health and Long Term Care requires an individual home submission and this requirement is assessed with each new funding opportunity. This process has continued since 2004 and is now used for other central applications, such as research due to the success the branch achieved in accessing funds with a centralized process.

Recommendation 26

That the Branch determine the appropriateness of the allocated costs, document the method of allocated administration costs and ensure that proper documentation is available for audit.

Management Response

Management agrees with this recommendation. Costs are allocated as per Financial Information Return (FIR) guidelines. The allocation methodology will be documented and kept on file for LTC staff and future audit requirements. This will be implemented by Q3 2009.

Recommendation 27

That the Branch, in concert with the FSU, develop policies and procedures for the management of trust accounting that are reflective of MOHLTC program standards and provincial legislation and regulations and which clearly define the accountabilities and responsibilities of the Branch and the FSU.

Management Response

Management agrees with this recommendation. LTC and the FSU currently comply with policies and procedures regulated under the Homes for the Aged and Rest Homes Act. Each year a third party financial audit is conducted to ensure compliance with specified ministry guidelines.

Financial Services and LTC will formalize and document current policies and procedures by Q4 2009.

Recommendation 28

That the Branch update the admission agreement to include charges of accommodation fees to the trust, as well as all other fees, authorized by residents' initials.

Management Response

Management agrees with this recommendation. Prior to this review, the admission agreement listed the services provided by LTC which the resident or power of attorney accepted as a whole. The admission agreement has now been updated to include areas adjacent to each service to be initialled upon admission.

Recommendation 29

That an annual review process be undertaken for each resident/family to ensure that the fees charged to the trust are agreed to.

Management Response

Management agrees with this recommendation. Currently, each resident/family receives a monthly statement outlining balance remaining, fees charged and closing balance of their trust account. In addition, commencing for the 2008 year-end, Financial Services will provide a consolidated annual statement for review.

Recommendation 30

That, at least annually, residents and families be surveyed on their financial experience in order to assess client service of the FSU.

Management Response

Management agrees with this recommendation. This is incorporated in the annual resident satisfaction survey that has been undertaken since 2001 as part of the OMBI reporting process.

Recommendation 31

That Management review the interest policy for trust accounts to determine if there are some increased interest income opportunities for residents.

Management Response

Management agrees with this recommendation. The Homes for the Aged and Rest Home Act (Regulation 637) limits the type of investments that trust accounts can enter into as it requires that funds are accessible by residents at all times. The resident trust accounts meet the requirements to have funds on demand and currently generate a return of prime less 1.75%, which is the most competitive rate on the market, as confirmed with the City's financial institution.

Recommendation 32

That Management review the signing authority with respect to the trust and the practice of closing off trust accounts and that improved controls over cheques be implemented.

Management Response

Management agrees with this recommendation. Signing authority for trust accounts has been implemented and forms part of the admission agreement.

The Auditor General states that control over cheques issued could be improved as cheques were found to be in open view. Financial Services operates in a secured area and cheques are locked away when not in use.

Recommendation 33

That the Branch review its accountability framework as it relates to financial requirements and move to an integrated budgeting approach in conjunction with the CPS Department and City as a whole.

Management Response

Management disagrees with this recommendation. The Auditor General has concluded that Corporate Finance provides guidelines and parameters for budgets and this practice leaves fewer opportunities for decision-making at the branch level. Management receives budget guidelines and parameters from City Council, not Corporate Finance. Yearly targets are identified through the branch hierarchy and are then reviewed at a branch/departmental level prior to being presented in the draft budget.

The Long Range Financial Plan also allows the branch to identify required needs within the City Operations department and the City as a whole.

Recommendation 34

That the Branch undertake an annual review be to assess potential efficiencies as well as revenue opportunities.

Management Response

Management agrees with this recommendation. An annual efficiency review is current practice. The first review was conducted through the Branch Process Review Program (BPRP) process in 2007 and included external benchmarking. LTC is currently concluding its second annual review through a Strategic Branch Review (SBR), which will be completed by the end of Q4 2008.

Recommendation 35

That the Branch move towards multi-year budgets taking life cycle costs and long term cost of capital into account in conjunction with PSAB compliance.

Management Response

Management agrees with this recommendation. LTC, along with all City branches participate in the annual budget process. Multi-year capital budgeting including lifecycle costing has been the practice since the City amalgamated and multi-year operating budgets were introduced in 2008.

Recommendation 36

That Branch operating budgets continue to be prepared on a per resident per day basis and that results be monitored for both expenses and revenues on that basis.

Management Response

Management agrees with this recommendation. The current practice is to prepare operating reports on a per resident per day basis so that results are monitored for both expenditures and revenues.

Recommendation 37

That Branch capital budgets be prepared on a life cycle cost basis to ensure that all costs are included in every capital project.

Management Response

Management agrees with this recommendation. While LTC receives a set allocation for minor capital, a lifecycle approach linked with the homes' preventative maintenance program, is used to identify capital replacement priorities across the four homes. These include: medical equipment, furniture, kitchen equipment, etc.

Recommendation 38

That the Branch and FSU collaborate to develop useful and timely variance reporting.

Management Response

Management agrees with this recommendation. Current practice is to provide monthly operating and capital reporting and ad hoc variance reporting as required. Financial Services will continue to review and develop the reports provided to ensure their effectiveness.

Recommendation 39

That the Branch in conjunction with the FSU develop an internal control framework with a full range of control policies including accounts receivable, inventory and tangible capital assets.

Management Response

Management agrees with this recommendation. Corporate policies are being developed on an ongoing basis as part of the Financial Control Framework. Accounts receivable policies are in place, however, are not fully documented. Proper documentation will be implemented by Q3 2009. With respect to tangible capital assets (TCA), the branch has postponed a fixed asset review until the new TCA protocol has been developed. Once the TCA protocol has been implemented appropriate counts and itemization will occur. Finance will comply with the PSAB 3150 requirement, coming into effect on 1 January 2009, for reporting on 2009 financial statements by mid 2010.

Recommendation 40

That the Branch review its payroll and scheduling process to determine if access cards can assist in payroll reconciliation.

Management Response

Management agrees with this recommendation. LTC and Human Resources will review the payroll and scheduling process to determine if access cards can assist in payroll reconciliation by the end of Q3 2009.

Recommendation 41

That the Branch work with the FSU to improve financial reporting and ensure PSAB compliance.

Management Response

Management agrees with this recommendation. Financial Services will continue to provide monthly operating and capital reports and ad hoc variance reporting as required. Finance will comply with the PSAB 3150 requirement, coming into effect on 1 January 2009, for reporting on the 2009 financial statements by mid 2010. New reporting standards are currently being developed by Financial Services and training of appropriate staff has commenced.

Recommendation 42

That the Branch review the need to staff a full time hairdresser in each home and the possibility of a contracted service (respecting the collective agreement).

Management Response

Management agrees with this recommendation. The City has a collective agreement provision that prevents contracting out of this service. LTC and Human Resources will work with the union to explore the possibility of exempting this service from the contracting out provisions in the collective agreement.

Recommendation 43

That the Branch review the food costs and recovery rates for Meals on Wheels, family meals, etc. to determine the appropriate rates.

Management Response

Management agrees with this recommendation. An annual review and contract process is currently in place. The annual process involves a review of food costs in long term care and considers any provincial increases that have been made to raw food.

Recommendation 44

That the Branch review its fundraising activities to assess possible revenue sources on behalf of residents.

Management Response

Management disagrees with this recommendation. The homes do not have a fundraising role. However, commencing February 2009, LTC will have staff representation on the new Long Term Care Prosperity Fund Board of Directors. This is a new community-based initiative with the intent to leverage community funds for supplemental long term care programs.

Recommendation 45

That the Branch ensure the most current admission agreement form is utilized for all new admissions across the homes.

Management Response

Management agrees with this recommendation and will ensure compliance with the current policy to use the updated form available on Ozone. A process has been in place since 2007 whereby current agreements are posted on Ozone to ensure admission agreement forms are consistent across all four homes.

Recommendation 46

That the FSU implement quality assurance measures to review admission documentation received from the social workers from each home including an admission checklist to ensure documentation is complete and an annual review process of the resident business files with a full trust and accommodation statement.

Management Response

Management agrees with this recommendation. A process to ensure completeness of the resident business files has been implemented. As well, trust and accommodation statements will be placed on file annually.

Recommendation 47

That the Branch develop improved access card procedures, particularly with respect to the issuance of cards to residents/families and to the processes for after hours cancellation.

Management Response

Management disagrees with this recommendation. Effective procedures are currently in place with respect to access cards. In addition, there is a process in place for immediate cancellation of cards after hours. The Power of Attorney for personal care has the authority to contact the Home's administrator to verbally change the access hours for a card during a situation of end of life care. The facility charge nurse has the authority to contact the administrator or their designate to authorize a change in card access after hours as per policy and procedure (reference no. 750:25 Access cards – Families and Residents). This policy will be reviewed with staff in Q2 2009.

Recommendation 48

That the homes provide access to the vestibules of the buildings in a manner that does not compromise the security of the building.

Management Response

Management agrees with this recommendation. LTC has previously investigated this possibility with Corporate Security and will revisit it again in Q2 2009. To mitigate the potential risk to residents from exposure to heat or cold, an access card is required to exit the homes, thereby reducing the likelihood that a resident cannot regain entry to the building. Furthermore, a doorbell is presently in place that rings at reception or to the charge nurse's cell phone to allow for timely access.

Recommendation 49

That the Branch implement policies regarding vendor access in unsecured and/or unmonitored areas of the building including notification to reception when vendors are in the building.

Management Response

Management agrees with this recommendation and will ensure compliance with current policy. Current practice is that staff accompanies unauthorized vendors as indicated in (policy and procedure reference no. 700:21: Security – Salespeople, Contractors, Trades people).

Recommendation 50

That the Branch review its health and safety terms of reference in light of the stipulations for workplace inspections with the Occupational Health and Safety Act.

Management Response

Management agrees with this recommendation. A comprehensive review was completed in 2007 and LTC branch practices were found to be compliant. As part of the regular review process, Occupational Health and Safety will review the terms of reference with LTC and will recommend and/or complete a revision where required, by the end of Q2 2009.

Recommendation 51

That during the next round of strategic planning for CPS, the Branch take on a more active role to ensure the vision of the Branch is reflected in the CPS Plan.

Management Response

Management disagrees with this recommendation. LTC is actively involved in departmental planning and believes that the branch vision is adequately reflected in the City Operation department's plan. Since 2001, LTC has had a strong focus on resident/customer satisfaction. Both the departmental and corporate plans reflect this vision.

Recommendation 52

That the business planning processes, reporting mechanisms and business plan format used by the Branch and homes be standardized, including quarterly reviews of the business and departmental plans and variance analyses to ensure early corrective actions.

Management Response

Management agrees with this recommendation. This process is already in place, has been supported by the FSU since 2006 and will be formally documented by Q3 2009 to ensure consistent practice.

Recommendation 53

That the Branch continue to perform an indicator needs analysis on an annual basis based upon quality management activities to ensure relevance of Balanced Scorecard indices.

Management Response

Management agrees with this recommendation and it is current practice. An annual review process has been in place since LTC implemented the balanced scorecard approach in 2005. The branch will continue to perform an annual

review of indicators as a part of this existing process that includes participation from all management levels in long term care. All managers have an opportunity to raise issues with indicators at their monthly functional team meetings, at quarterly LTC meetings and at the formal annual review of the balanced scorecard process. These submissions can be written or verbal. In the Q4 2009 review of terms of reference a documented requirement for a written submission of indicators will be considered.

Recommendation 54

That, as part of the implementation of Telestaff, the practice of generating staff models reports be established.

Management Response

Management agrees with this recommendation and confirms that it is part of the implementation plan. This is included in the phased implementation plan for Telestaff. Homes already implemented are currently receiving reports. Regular management reporting mechanisms will be fully established by Q3 2009.

Recommendation 55

That the Branch assess the risk of absence of the sole staff member responsible for the Balanced Scorecard indicators and respond with an appropriate contingency plan.

Management Response

Management disagrees with this recommendation. This function is not that of a sole staff member. All managers are responsible for entering their program data into the balanced scorecard templates and there is a manager with oversight responsibility for the program. To date there have been no issues with this approach, which is reviewed annually as part of strategic and operational planning process.

Recommendation 56

That respective roles and responsibilities of the FSU, RPAM, Employee Services, Branch staff and home staff be documented within a service agreement with performance standards and expectations.

Management Response

Management agrees with this recommendation. Service level agreements currently exist, but will be updated to reflect specific roles and responsibilities, performance standards and expectations.

Human Resources will work with LTC to update their service level agreement by the end of Q2 2009. RPAM will begin work with LTC to develop a service level

agreement in Q3 2009. With respect to the FSU, roles and responsibilities will be documented as organizational restructuring develops. This will be completed by Q1 2010.

Recommendation 57

That the orientation program provided for new City Councillors incorporate a segment that outlines their responsibilities under the LTC Act and the OHS Act.

Management Response

Management agrees with this recommendation. As part of the next new Councillor orientation program, LTC will review information provided and will ensure that materials are updated to reflect any changes with respect to the new *Long Term Care Homes Act* by Q3 2010. In addition, Occupational Health and Safety (OH&S) will incorporate an overview of the employer's responsibilities under the *OH&S Act*.

Recommendation 58

That performance reviews be completed on a regular basis to assess training requirements and re-establish commitments and set goals for the upcoming years.

Management Response

Management agrees with this recommendation. Current practice is that annual performance reviews are completed for full-time CUPE 503 and CIPP staff and, every two years for part-time and casual CUPE 503 staff. A staff performance review database is maintained to ensure targets are met and managers are provided with a monthly report listing performance appraisals due for the month. Performance appraisals for supervisors and managers include an expectation for performance appraisal completion with staff and outcomes are monitored through this process. A pilot project was initiated at Armstrong Home in Q4 2008 to submit the training and development plan portion of all staff performance appraisals to the coordinator of training and development to facilitate an analysis of the types of issues identified in developmental plans. Pending the outcome of this pilot project, changes to the process will be introduced to all homes in Q1 2010.

Recommendation 59

That, following the implementation of Telestaff, the Branch and FSU work together to produce staffing reports to measure against effectiveness of the Service Delivery Model.

Management Response

Management agrees with this recommendation. LTC, Financial Services and Human Resources will develop reports to measure service delivery model effectiveness following implementation of Telestaff in Q3 2009.

Recommendation 60

That quality management plans and initiatives be discussed regularly at the Branch level to establish their standardized requirements and to promote consistency amongst homes.

Management Response

Management agrees with this recommendation. Quality management plans have been reviewed quarterly at branch management team meetings and annually in concert with home managers since 2007. The quality management program is documented in policy and procedure 700:34 and was revised in Q1 2009 to reflect changes to the balanced scorecard program reporting process.

Recommendation 61

That the Branch and its homes continue to utilize quality management indicators to inform their reviews of policy and practice and that a routine review of the indicators be undertaken to ensure that they remain relevant to the organization as measures that assist in the monitoring of care and service quality, and mitigate the potential for undue risk.

Management Response

Management agrees with this recommendation.

Quality indicators are reviewed quarterly and work plans are established annually, and as part of the of the three-year accreditation process. The quality management program is documented in policy and procedure 700:34 and was revised in Q1 2009 to reflect changes to the balanced scorecard program reporting process.

Recommendation 62

That the Branch continue to explore cost effective methods to gain access to industry best practices with planned implementation of these practices throughout the organization.

Management Response

Management agrees with this recommendation. LTC undergoes an annual efficiency review and participates in OMBI. A recent realignment of the supervisor of Resident Care position in each home to the coordinator of Best Practice will allow a broader sector and interdisciplinary approach to these

annual reviews and will include such components as provincial and national associations, content experts, conference proceedings, literature reviews and peer reviewed journals.

Recommendation 63

That the Branch continue their current active involvement and encourage others to become involved in local seniors' and long term care issues so that the City's LTC visibility is promoted.

Management Response

Management agrees with this recommendation and this is current practice. For the past four decades, LTC has led senior's initiatives and participated in long term care sector partnerships and community partnerships, such as Successful Aging Ottawa, the United Way/Centraide Seniors Impact Council, the Senior's Agenda, the Champlain Dementia Network and the Regional Geriatric Advisory Committee to improve the role of LTC and promote research and best practice in City LTC homes. This leadership role has traditionally been the responsibility of the Director LTC and will be continued wherever possible within current staffing and management levels.

Recommendation 64

That the Branch review training requirements in light of mandatory requirements as well as professional practice.

Management Response

Management agrees with this recommendation and the current practice will be formally documented as a policy to ensure consistency. Mandatory training is reviewed annually to ensure it is up-to-date with current practice. Professional training is reviewed annually to ensure regulatory requirements are met.

Recommendation 65

That the Branch review the requisite skills and roles of the social worker position to determine the best use of this staff position from the joint perspectives of its contribution to the interdisciplinary care to residents and cost effectiveness.

Management Response

Management agrees with this recommendation. This position is presently under review to identify the elements of the position that are administrative and the elements of the position that draw on social work expertise. Job evaluation results are expected to be complete by Q1 2010.

Recommendation 66

That more cooperative purchasing be pursued across all homes.

Management Response

Management agrees with this recommendation. LTC implemented a cooperative purchasing process in 2007 through a consolidation of the request for tender process across the homes. Purchasing for medical supplies, food and environmental services is coordinated through standing offers.

Recommendation 67

That project plans for the Goldcare and Telestaff projects be developed to include successes to date, milestones, training and deliverables with a view to facilitating timely implementation processes.

Management Response

Management agrees with this recommendation. Project plans for the Goldcare and Telestaff projects were developed by long term care to secure initial project funding and support from IT services. Telestaff has a multi-phase implementation plan, which will be completed by Q3 2009. A steering committee has been established to identify strategic opportunities and areas for policy development with regard to the ongoing use of the Goldcare system. In addition, a Goldcare user group has been established to support staff in the resolution of ongoing user issues and to identify additional user requirements related to annual software upgrades.

Recommendation 68

That upon implementation of the Telestaff system, the Branch and FSU work together to develop a regular schedule of reports and variance analyses that will assist managers in determining appropriate staffing levels.

Management Response

Management agrees with this recommendation. LTC, Financial Services and Human Resources will develop reports to measure service delivery model effectiveness following implementation of Telestaff in Q3 2009.

Recommendation 69

That the various survey tools be reviewed on a regular basis to ensure the questions are generating meaningful, useful information and to determine the relevance of the content for service improvement purposes across all operational domains.

Management Response

Management agrees with this recommendation. Survey tools, such as the resident satisfaction survey, the staff needs assessment survey, the palliative care survey, the admission survey, etc. are reviewed on an annual basis before they are re-implemented. As an example, in 2008 the resident satisfaction survey was

modified to allow more detailed information in specific service areas to allow managers to capture specific program data to facilitate modification of their program offerings.

Recommendation 70

That the Branch and FSU engage in discussions with the PSAB lead at the City to assess the impact on LTC reporting in a full accrual accounting environment.

Management Response

Management agrees with this recommendation. Discussions have already taken place and will continue into the future to ensure that PSAB 3150 requirements are met prior to the 2009 reporting of financial statements by mid 2010.

Recommendation 71

That the Branch, in consultation with RPAM, develop a long-range asset management plan that encompasses a replacement plan over a minimum 20-year horizon for all buildings and equipment.

Management Response

Management agrees with this recommendation. As the corporate landlord, RPAM has conducted the necessary condition reviews on Carleton Lodge, Centre d'Accueil Champlain and Peter D. Clark Home in order to establish a long-range capital lifecycle renewal plan and comprehensive asset management plan for the City's long term care facilities. The results of these condition reviews have been factored into the overall lifecycle renewal plan over the next 20 years with a significant investment already being made, most notably, at Carleton Lodge. As it is a newer facility, a condition review of the Garry J. Armstrong Home will take place in five years time and the result will be incorporated into the overall lifecycle renewal program.

Recommendation 72

That the Branch implement an inventory management system, including food management and medical supplies inventory.

Management Response

Management agrees with this recommendation.

The City is committed to protecting the assets of the corporation. Operational directors within the corporation are accountable for the control and safeguard of City assets they use in the delivery of services and are in the best position to align appropriate controls with their operational requirements. This is clearly stated under 'Management Responsibilities' within the City's Code of Conduct where it states: "The management of the City is accountable for protecting the assets of, and the public trust in, the City. Towards this end, management must

make every effort to establish and maintain adequate systems, procedures and controls to prevent and detect fraud, theft, and breach of trust, conflict of interest, bias and any other form of wrongdoing."

There are corporate policies in place covering the capitalization, depreciation, identification, accounting, recording and safeguarding of City assets and inventory and these are clearly outlined in the responsibilities within the corporation. The food, medical supplies or other consumable materials used by the LTC branch are items expensed during the year and are not within a major asset class and do not go into a stores inventory system. The significant majority of these supplies and materials are purchased on a "just in time basis", are expensed and immediately consumed or used. Those items relate to purchases made in the delivery of LTC services and are not appropriate items for inclusion in inventory.

Notwithstanding, LTC in conjunction with Financial Services will review the current systems and will implement, where necessary, an inventory management system, additional controls or mitigating measures to limit risk. Funding requirements will be identified in the 2010 budget. This will be implemented by Q3 2010.

Recommendation 73

That the Branch and its education coordinators revisit the attendance target for in-service training and explore the best practices that have been developed by other homes to facilitate the comprehensive, cost effective strategies for delivering the MOHLTC mandatory training sessions to all staff on an annual basis.

Management Response

Management agrees with this recommendation and a review is underway. In an effort to continuously improve delivery and effectiveness of mandatory training programs, management is presently reviewing the delivery model. A recommendation regarding possible changes will be brought to branch management team in Q2 2009.

Recommendation 74

That the Branch develop a comprehensive staff development trainers' manual with comprehensive training profiles for each in-service topic.

Management Response

Management agrees with this recommendation and it is being implemented. LTC will consolidate existing training programs, develop a comprehensive manual which includes all items covered in general staff orientation, and will post it on Ozone by Q4 2008.

Recommendation 75

That the Branch develop a Staff Investment Strategy Framework to guide the home-specific training efforts and to align scarce resources for staff development effectively.

Management Response

Management agrees with this recommendation. The Learning and Growth Committee identifies training needs through the annual staff needs assessment. The Learning and Growth team submits an annual training plan for approval to the branch management team. The priority for funded staff attendance at training is established based on needs identified in this annual plan.

Conclusion

The LTC Branch and its four homes provide quality resident-centred care and services. Furthermore, the homes have put into practice the Resident Bill of Rights, they reflect adherence to the MOHLTC compliance standards and consistently follow, for the most part, the Branch policies. Although the homes, on occasion, were found to have unmet standards, the compliance issues were addressed in a timely and appropriate manner with the exception of mandatory in-service training sessions on an annual basis for 100% of staff and Food Service Worker Certification. There are examples of innovation and creative program development within the Branch and at specific homes. These advances and successes in care and service practices routinely shared across the organization for implementation as new best practices. There remain, however, notable differences between homes despite significant, ongoing standardization efforts.

With respect to the trust and accommodation accounting performed by the FSU, there are significant deficiencies in records management. Although there have been few complaints, the lack of policies and written procedures as well as documentary evidence poses risks for the City. These practices need to be reviewed in light of the MOHLTC program standards and the Trust Act. The practices should be revised to ensure proper and thorough documentation is present in all resident files. A new satisfaction survey should be developed to measure the success of these initiatives.

The Branch should review its financial management and accountability framework. There is an inherent lack of inventory/asset controls as well as limited oversight and long term vision in this area. There is lack of adequate reporting mechanisms available to the management to ensure proper prudence and probity over public funds. Budgetary processes have not embraced modern comptrollership practices and tend to be developed from a top down approach rather than involvement from various levels of management. Furthermore, budgets are developed based upon affordability rather than need and do not reflect life cycle costs or capital plans over the long term.

Acknowledgement

We wish to express appreciation to the staff and management of the LTC Branch; direct care and service staff and management of the LTC homes; and staff of the COEs, for their cooperation and assistance throughout the audit process.

RÉSUMÉ

Introduction

La vérification de la Direction des soins de longue durée figurait dans le plan de vérification de 2008 du Bureau du vérificateur général, document soumis pour la première fois au Conseil municipal en mai 2005.

Contexte

Au moment de cette vérification, la Direction des soins de longue durée (DSLD) faisait partie des Services communautaires et de protection et relevait du directeur municipal adjoint. La Direction se composait de quatre foyers de soins de longue durée dont chacun était géré par un administrateur relevant du directeur des Soins de longue durée. À la fin de 2008, la Direction des soins de longue durée a été dissoute; à l'heure actuelle, l'administrateur de chacun des foyers relève du directeur général, Services sociaux. Comme la vérification est antérieure à cette réorganisation, le rapport porte sur la structure administrative précédente.

Les foyers ont reçu l'appui du volet administratif de la Direction, ainsi que des Centres d'excellence (CE). Ces derniers sont formés de l'Unité du soutien financier (USF), de la Gestion des biens immobiliers (GBI) et des Services aux employés, notamment Santé et sécurité.

D'ici à ce que la nouvelle *Loi sur les foyers de soins de longue durée* (2007) reçoive la sanction royale, les foyers de la Ville sont toujours régis par la *Loi sur les foyers pour personnes âgées et les maisons de repos* (la Loi) et les ententes de service conclues avec le ministère de la Santé et des Soins de longue durée (MSSLD).

La Loi fait également état d'un principe fondamental qui constitue un facteur clé dans le cadre de cette vérification, soit le fait que les résidents des foyers de la Ville sont en droit de recevoir des soins et des services de qualité satisfaisant leurs besoins. Ce principe, selon son énoncé du paragraphe 1.1(1) de la Loi, stipule que :

> *« Pour interpréter la présente loi, les règlements et une entente de services relative à un foyer, le principe fondamental qui doit être appliqué est celui selon lequel un foyer est avant tout le foyer des résidents. À ce titre, il doit fonctionner de manière à répondre de façon satisfaisante aux besoins physiques, psychologiques, sociaux, culturels et spirituels de chacun des résidents et à donner à ceux-ci l'occasion de satisfaire, selon leurs capacités, les besoins physiques, psychologiques, sociaux, culturels et spirituels des autres. »*

Selon les modalités de l'entente de services conclue entre les foyers de la Ville et le MSSDL, la Ville consent à assurer le fonctionnement des foyers conformément aux dispositions de la Loi. Le niveau de conformité à la Loi observé dans le fonctionnement des foyers est déterminé à l'aide d'un programme annuel d'examen

de l'observation mis en application par les conseillers-inspecteurs de la Direction de l'amélioration de la performance et de la conformité du MSSLD. Les foyers participent en outre à l'évaluation volontaire réalisée par le Conseil canadien d'agrément des services de santé.

La Direction exploite un total de 711 lits répartis dans ses quatre foyers, soit 15 pour cent des 4 694 lits réservés aux soins de longue durée dans la Ville d'Ottawa. Les quatre foyers sont dispersés géographiquement dans Ottawa, et chacun d'eux se fait le reflet de caractéristiques, de services et de cultures organisationnelles uniques.

Foyer de SLD	Nombre de lits	Emplacement	Date d'ouverture d'un immeuble, nouveau ou rénové	Conformité à la structure du MSSDL	Caractéristi-ques uniques
Carleton Lodge (CL)	160	Nepean	1989	A	PAAF sur place
Centre d'accueil Champlain (CAC)	160	Vanier	1998	A	PAAF sur place Francophone
Garry-J.-Armstrong (GJA)	180	Ottawa-Centre	2005	A	Bilingue
Centre Peter-D.-Clark (PDC)	211	Centrepointe	2001	A	Bungalows
Total des lits municipaux	711				

Le budget d'exploitation de la Direction s'élevait à 46,3 millions de dollars pour 2007, comportant une nécessité de prélèvement net de 8,1 millions de dollars faisant exception des obligations.

Objectifs de la vérification

En tant que vérification, cette affectation faisait appel aux trois composants suivants : conformité, optimisation des ressources et états financiers axés principalement sur l'élément rendement (optimisation des ressources). Ce dernier élément de la vérification vise à évaluer la suffisance des systèmes de gestion, des contrôles et des pratiques, notamment ceux destinés à contrôler et à sauvegarder les actifs de façon à ce que toute l'importance soit accordée à l'économie, à l'efficience et à l'efficacité. De plus, l'efficacité des programmes et des services constitue un élément clé de ces types de vérification. Lorsqu'il est question de vérification de la conformité aux autorisations législatives et aux autorisations connexes, le but visé consiste à exprimer une opinion sur le respect ou non, par l'entité, des prescriptions d'une loi particulière et d'autorisations données.

Comme il s'agit de la vérification d'un organisme du secteur public, les normes de comptabilité et de vérification du Conseil sur la comptabilité dans le secteur public

(CCSP) s'appliquent (soit SP 5300 Vérification de la conformité aux autorisations législatives et aux autorisations connexes dans le secteur public, SP 5400 Vérification de l'optimisation des ressources dans le secteur public). Les vérificateurs suivent également les pratiques recommandées par la Fondation canadienne pour la vérification intégrée relative à la vérification générale et à la vérification de l'optimisation des ressources.

Portée de la vérification

La portée de cette vérification englobe les quatre foyers de soins de longue durée exploités par la Direction des soins de longue durée de la Ville d'Ottawa. Compte tenu de la structure de la Direction et des services financiers, cette vérification a nécessité une analyse approfondie et une interaction avec l'Unité du soutien financier responsable des Soins de longue durée et de la Santé publique, ainsi que d'autres centres d'excellence. La vérification comportait trois volets, soit conformité, finances et rendement (optimisation des ressources), l'investigation insistant davantage sur ce dernier point. Bien que disposant de données et de renseignements pour les exercices de 2001 à 2007, la vérification a porté sur deux exercices, soit 2006 et 2007.

Outre les trois volets de la vérification énoncés plus haut, ce rapport présente un résumé de l'analyse menée en 2001 par l'ancienne Direction des services de vérification et de consultation relativement aux autres options possibles en matière de prestation des services liés aux soins de longue durée.

Sommaire des principales constatations

Généralités

1. Dans l'ensemble, les observations découlant de la vérification ont montré que la DSLD et les foyers offrent des soins et des services de qualité aux résidents domiciliés dans les foyers de la Ville : ces derniers sont bien traités et les immeubles dans lesquels ils vivent, bien entretenus. Les niveaux élevés de satisfaction de la clientèle confirment cette constatation favorable de la vérification. Les foyers offrent des milieux de vie confortables et sécuritaires, qui fournissent aux résidents quantité de possibilités et d'aide leur permettant d'avoir une bonne qualité de vie. De nombreuses initiatives opérationnelles et cliniques, nouvelles et émergentes, témoignent de l'engagement des foyers de recourir aux pratiques exemplaires et d'améliorer la qualité. Les foyers valorisent l'établissement de relations entre la population résidante, les familles, les amis et le personnel.

2. La Ville arrondit les opérations d'un impôt prélevé à partir du financement du niveau de soins et de l'enveloppe du MSSLD. Il s'agit là d'une pratique courante dans les foyers municipaux de la province. Les restrictions financières auxquelles sont soumises toutes les municipalités, y compris la Ville d'Ottawa,

les ont poussées à accentuer la réduction des coûts et l'amélioration de l'efficience opérationnelle. Si les foyers de la Ville ont entrepris de tels efforts, d'autres possibilités sont également exploitables. Ces efforts pour réduire les coûts nécessiteront en outre une planification portant sur une plus longue période puisque les immeubles relativement nouveaux et leurs systèmes continueront de prendre de l'âge.

3. Quelques projets clés, actuellement en cours, favoriseront l'amélioration continue de l'efficacité et de l'efficience opérationnelles, tout en présentant des possibilités d'accroissement des recettes. Il est question plus particulièrement de la mise en place de Goldcare (système de documentation des soins aux résidents) et de Telestaff (système d'ordonnancement du personnel), deux systèmes qui présentent des possibilités de rehausser l'efficacité de la documentation et l'efficience du personnel.

4. Bien que les centres d'excellence fournissent un bon service à la DSLD et aux foyers, l'importante séparation des fonctions entre les unités et les foyers influe sur l'efficacité des opérations et se répercute sur la responsabilisation des niveaux de gestion de la Direction et des foyers. Cette situation est particulièrement apparente dans la responsabilité comptable relative aux budgets, aux comptes en fiducie et à la facturation de l'hébergement. L'établissement de rapports financiers est entrepris à un niveau très poussé, et les gestionnaires ont dû élaborer leurs propres systèmes pour faciliter la prise de décisions. Même si le système financier de la Ville, SAP, est considéré comme étant ultramoderne dans l'industrie, il ne fournit pas un certain nombre de données nécessaires en ce qui a trait aux soins de longue durée.

Conformité

1. Les rapports sur la conformité du MSSLD permettent de déceler quelques normes non satisfaites (p. ex. séances obligatoires de formation en milieu d'emploi sur une base annuelle offertes à la totalité du personnel et accréditation des travailleurs des services alimentaires), ce qui donne à croire que les foyers font preuve de diligence dans les efforts visant à exploiter leurs installations dans le respect des politiques, des normes et des lois régissant les opérations de soins de longue durée. Dans certains cas, quelques foyers ont réagi rapidement en vue d'accorder la priorité aux problèmes de conformité, ce qui les a amenés à présenter dernièrement des rapports plus favorables. Il est toutefois inhabituel, dans un organisme comportant de multiples installations de soins de longue durée, que les plans de conformité ne soient pas acheminés à une compétence centrale ou à une autre personne désignée qui examinera de façon comparative l'uniformité des approches et des engagements avant leur soumission au MSSLD.

2. Les politiques et les procédures sont détaillées et, en général, bien comprises par les gestionnaires et le personnel. Toutefois, il serait judicieux de profiter de

l'occasion offerte par le processus continu d'élaboration de politiques et d'examen de celles-ci pour parfaire l'organisation et la structure des manuels.

3. Il existe quelques inconsistances, au niveau des foyers, en ce qui a trait à la mise en application et à l'observation des politiques. De plus, on observe une normalisation restreinte des pratiques de documentation dans les foyers. Des inconsistances sont également observées dans l'interprétation du processus de changement des politiques et des procédures.
4. La Direction compte énormément sur Santé et Mieux-être des employés pour obtenir des conseils en matière de santé et de sécurité au travail. Il existe une possibilité de revoir et de mettre à jour l'organisation et la structure des politiques de santé et de sécurité, et de comparer ces politiques au règlement sur les soins de santé. En outre, le mandat du Comité mixte de santé et de sécurité au travail comporte une disposition concernant l'inspection des lieux de travail qui se révèle contraire aux dispositions prévues dans la *Loi sur la santé et la sécurité au travail.*
5. Les exigences en matière de formation et la politique relative à la formation du personnel ne répondent pas entièrement aux attentes en matière de formation obligatoire formulées par le MSSLD. La cible quant à la participation du personnel à la formation est établie à un niveau bien inférieur à 100 % de l'effectif. De plus, il n'existe aucun manuel de formation complet présentant les objectifs d'apprentissage visés pour chaque sujet de la formation obligatoire, ce qui limite l'efficacité des efforts d'évaluation de la formation.
6. Les politiques et les pratiques en matière d'achats ne sont pas observées de manière uniforme ou congruente. De plus, aucun système de gestion des stocks n'est en place pour s'assurer que les articles sont distribués de façon appropriée et imputés au bon centre de coûts. La gestion des stocks est telle que la direction ne peut être certaine que les actifs sont bien protégés.
7. Les pratiques de comptabilité de fiducie et de l'hébergement manquent de documentation appropriées et ne respectent pas entièrement les normes du programme établies par le MSSLD. Le personnel des foyers dispose d'un minimumde direction, et il n'y a pas de processus complet ou uniforme d'examen/de mise à jour de l'entente annuelle relative à l'admission.
8. En ce qui a trait aux comptes débiteurs, aucune politique ne les régit. Les politiques sont non écrites et informelles. Par conséquent, il est possible que la Ville ne réalise pas toutes les recettes et les possibilités d'investissements auxquelles elle a droit.

Gestion financière

1. Les foyers satisfont aux exigences les obligeant à offrir au moins 40 % de leurs lits respectifs au taux d'hébergement de base. Au niveau de la Direction, comme

il s'agit d'hébergements collectifs, les foyers dépassent les exigences en matière d'hébergement de base. On s'accorde à reconnaître que Garry J. Armstrong éprouve toujours des difficultés à optimiser ses recettes privilégiées.

2. La compréhension des dépenses admissibles que permet le MSSLD pour chaque enveloppe budgétaire est limitée. Ainsi, on connaissait peu ou pas les répercussions qu'un passage à une comptabilité d'exercice intégrale, exigée par le CCSP, pourraient avoir sur le présent rapport. Le MSSLD doit encore modifier les normes de ce programme à la lumière des changements du CCSP.

3. La mise en œuvre de Goldcare pourrait constituer une occasion idéale pour améliorer la documentation sur les soins aux résidents et, ce faisant, aider les foyers à rehausser leur mesure de composition de la clientèle (MCC)/ et de l'indice de composition de la clientèle (ICC). Ces hausses se répercuteront par la suite sur le financement de leur niveau de soins, dans l'enveloppe réservée aux soins infirmiers et aux soins de la personne.

4. Les dossiers administratifs des résidents manquent d'organisation proprement dite, d'uniformité et de documentation requise. Certains frais imputés aux comptes en fiducie des résidents ne sont pas accompagnés de justification ou d'autorisation. Le personnel des foyers ne dispose pas des renseignements nécessaires pour déterminer si des frais particuliers peuvent ou non être imputés au résident, puisqu'il n'a pas accès aux renseignements spécifiques de chaque résident.

5. Les Services financiers de la Ville donnent les directives relatives au budget et les paramètres des budgets des foyers de soins de longue durée. Cette pratique laisse peu de place à la prise de décisions au sein de la Direction ou dans chacun des foyers. La Direction reçoit des objectifs descendants, qu'elle doit atteindre sans procéder à une évaluation des risques pour les soins aux résidents et pour le fonctionnement de l'immeuble.

6. Au sein de la DSLD et de l'USF, on observe une piètre compréhension du CCSP ou des nouvelles normes en matière de présentation de rapports.

7. À l'heure actuelle, chaque foyer emploie du personnel fournissant des services qui, idéalement, devraient entraîner une récupération totale des coûts (p. ex. coiffeur). Dans un certain nombre de cas, ces récupérations de coûts ne sont pas réalisées; il existe une possibilité d'évaluer ces services en les comparant aux pratiques normales observées dans l'industrie des soins de longue durée.

8. En matière de récupération des coûts liés à l'alimentation, on observe quelques problèmes propres à la vente de services de restauration et de repas. La Direction effectue un suivi des coûts et du recouvrement. Il est apparent, dans leur rapprochement de comptes, que ces coûts ne sont pas récupérés. Bien qu'il n'y ait aucune attente de récupération totale, les processus de gestion de trésorerie comportent de grandes lacunes à cet égard. De même, les

gestionnaires ont reconnu que les articles en papier ne sont pas imputés à leurs coûts.

Rendement

1. Il manque d'indicateurs de dotation permettant d'évaluer l'efficacité et l'efficience du modèle de prestation des services.
2. Les sondages auprès des résidents et des familles révèlent des niveaux de satisfaction très élevés dans les foyers dans tous les domaines relatifs aux soins et aux services. Certaines tendances dignes de mention (soit une chute des résultats relatifs à la satisfaction des familles dans un foyer) font en sorte que toute l'attention des équipes de gestion est tournée vers le foyer visé.
3. Les sondages auprès des résidents et des familles ont une portée limitée sur les questions financières et les services. Par conséquent, les niveaux de service pourraient ne pas faire l'objet d'une recherche approfondie.
4. La gestion des stocks est lacunaire; par ailleurs, aucune analyse n'est entreprise pour examiner leur utilisation et les fuites potentielles. Les systèmes de gestion des stocks sont faibles ou inexistants.
5. La mise en œuvre de technologie (Goldcare et Telestaff) est encore aux premiers stades, mais n'est pas régie par de véritables pratiques de gestion de projet.

Autres options possibles en matière de prestation des services

Une évaluation des autres options possibles en matière de prestation des services en soins de longue durée ne faisait pas partie du plan de la présente vérification. Toutefois, en 2001, la direction avait demandé à l'ancienne Direction des services de vérification et de consultation d'effectuer une analyse des modèles possibles de prestation des services en soins de longue durée afin de s'assurer que la Ville optimisait ses économies potentielles et qu'elle utilisait l'argent des contribuables de la manière la plus efficace possible. Nous avons jugé pertinent d'inclure à ce rapport de vérification un résumé de cette étude de 2001 à l'intention de la direction et du Conseil aux fins d'examen.

Comme une analyse a été entreprise dans l'examen de 2001, et plus particulièrement en raison des contraintes législatives et de conventions collectives, un dessaisissement complet du programme des soins de longue durée de la Ville n'est pas une option réaliste à court terme. Le Conseil souhaitera peut-être accorder plus d'attention à d'autres options, plus particulièrement un contrat de gestion par le secteur privé, la cession à un organisme à but non lucratif ou le maintien des soins de longue durée comme un service direct de la Ville.

Recommandation 1

Que la direction ait à sa disposition les statistiques en matière de dotation des foyers pour être en mesure de confirmer d'emblée que les exigences normales

sont satisfaites (p. ex. accréditation des travailleurs des services alimentaires, renouvellement annuel de l'inscription du personnel et statut de l'attestation de compétence en RCR, et autres).

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'il s'agit d'une pratique courante. Les gestionnaires ont actuellement accès aux statistiques en matière de dotation en faisant une demande de renseignements à l'administration, qui imprimera un rapport tiré de la base de données sur la formation et le perfectionnement du personnel en soins de longue durée, ainsi que du dossier personnel de l'employé. Les renseignements contenus dans la base de données sur la formation et le perfectionnement du personnel doivent être convertis en SAP au premier trimestre de 2009; ils continueront d'être à la disposition du personnel administratif, et les gestionnaires y auront accès à partir de leur ordinateur de bureau.

Recommandation 2

Que la Direction examine la norme du MSSLD en matière de formation obligatoire, évalue le respect de celle-ci et révise en conséquence son objectif en vue de répondre à l'attente voulant que 100 % du personnel assiste à toutes les séances annuelles de formation obligatoire, conformément aux normes du MSSLD.

Réponse de la direction

La direction est d'accord avec cette recommandation. Il est toutefois important de noter qu'il y a une différence entre les exigences en matière de formation obligatoire établies par le ministère de la Santé et des Soins de longue durée et les cours de perfectionnement offerts par la DSLD.

Dans un effort pour améliorer la prestation et l'efficacité des programmes de formation obligatoire, la direction a examiné un modèle de prestation de la formation qui permettrait d'assurer que la totalité de la formation a été suivie par tous les membres du personnel à temps plein, à temps partiel et occasionnel. Les coûts estimés de ce modèle s'élèvent à 195 000 $ pour la participation du personnel, et à 90 000 $ pour la mise en œuvre. Le financement de ce modèle sera à rappeler en tant que pression décelée sur le budget de 2010 des Soins de longue durée.

Recommandation 3

Que la Direction élabore un processus faisant en sorte que les plans de conformité fassent l'objet d'un examen détaillé centralisé aux fins d'uniformité avant d'être présentés et qu'ils soient accessibles aux autres foyers, en vue de permettre à tous les foyers de se montrer plus proactifs et de s'assurer que leur foyer respecte ou dépasse les normes de conformité.

Réponse de la direction

La direction est d’accord avec cette recommandation. Le directeur des soins de longue durée revoit actuellement tous les plans de conformité avant de les présenter au MSSLD. De plus, l’équipe de direction de la DSLD (qui comprend des représentants des quatre foyers de la Ville) examine les plans de conformité annuels afin de déterminer les politiques, les procédures et les pratiques exemplaires à mettre en place. Le processus sera documenté afin de donner des précisions aux gestionnaires qui ne sont pas conformes. Les plans de conformité sont disponibles à un niveau central, dans les bureaux de la Direction. La possibilité de les rendre accessibles par voie électronique sera examinée au deuxième trimestre de 2009.

Recommandation 4

Que, durant la prochaine ronde d'examens des politiques, une restructuration soit faite en vue de faciliter la recherche de politiques appropriées par les membres des différents échelons du personnel (p. ex. disposer de sections distinctes pour les renseignements sur les résidents, les comptes en fiducie, les ressources humaines et autres).

Réponse de la direction

La direction est d’accord avec cette recommandation. Les politiques en matière de soins de longue durée sont actuellement réparties dans les catégories suivantes : services alimentaires, buanderie, entretien ménager, soins aux résidents, loisirs, travail social, soins de santé, prévention et contrôle des infections, santé et sécurité, intervention en cas d’urgence et administration (foyer/bureaux et Direction).

Les politiques en matière de comptabilité de fiducie sont tenues à jour par l’USF. Celles en matière de ressources humaines sont municipales. Le personnel a accès à toutes les politiques municipales et à celles en matière de soins de longue durée par l'entremise d'Ozone. De plus, les politiques en matière de SLD sont fournies dans des manuels imprimés placés dans les aires désignées de chaque foyer et des bureaux de la Direction; ce fait a été mentionné durant les réunions générales avec le personnel et dans les réunions de gestion. L'emplacement des politiques propres aux SLD par domaine de service sera revue au cours du cycle complet de trois ans. Le prochain cycle débute à l'été 2009. Dans le cadre de ce processus, le personnel examinera les manuels de politiques et de procédures, ainsi que les indices associés en provenance d'autres organismes de SLD ayant une envergure et une structure comparables.

Recommandation 5

Que la Direction détermine des emplacements clés pour le rangement des manuels sur les politiques afin de veiller à ce que le personnel ait facilement

accès aux renseignements nécessaires et qu'elle ait un moyen de vérifier qu'ils restent d'actualité.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les bureaux de la Direction désignent actuellement des emplacements pour les manuels sur les procédures et les politiques, qui seront inscrits sur une liste mise à jour, conformément à ce qui est mentionné dans les politiques et les procédures (référence n° 700:02 Manuel des politiques et des procédures) approuvées en novembre 2005 et révisées en mars 2006. Dans chaque foyer, les assistantes administratives sont chargées de remplacer les anciennes versions des politiques et des procédures des manuels par les nouvelles. En outre, toutes les politiques et les procédures en matière de SLD sont accessibles depuis 2007 par l'entremise d'Ozone. L'emplacement, physique et électronique, des politiques propres aux soins de longue durée par domaine de services sera examiné dans le cadre du cycle complet de trois ans. Le prochain cycle débute à l'été 2009.

Recommandation 6

Que la Direction revoie ses pratiques concernant les politiques propres aux foyers afin de déterminer quelles politiques et/ou quelles feuilles de calcul doivent être spécifiques aux foyers et lesquelles mérite d'être plus axées sur la Direction, afin de favoriser l'uniformité.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les SLD disposent d'une politique et d'une procédure relatives au processus d'élaboration des nouvelles politiques et procédures (référence n° 700:02 Manuel de politiques et de procédures). L'approbation de toutes les politiques et de toutes les procédures est confiée à un groupe désigné, et toutes les politiques propres aux foyers doivent être présentées à l'organe approbateur aux fins d'examen et d'approbation.

Cet examen du niveau de conformité n'a peut-être pas été clairement énoncé dans le document sur les politiques et les procédures; par conséquent, il a été modifié pour tenir compte de l'obligation, pour l'équipe de direction de la DSLD, de consulter les politiques et les procédures propres aux foyers aux fins d'examen et d'approbation.

Recommandation 7

Que le cycle de trois ans relatif à l'examen des politiques de la Direction intègre un plan de travail mettant en évidence les politiques à revoir et les dates cibles.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les plans de travail mettant en évidence les dates cibles pour l'examen des politiques sont coordonnés par domaine de l'équipe fonctionnelle qui détient les pouvoirs d'approbation des politiques et des procédures. Les SLD examineront la centralisation de ces plans de travail au premier trimestre de 2009 et intégreront cette exigence au mandat de l'équipe fonctionnelle. De plus, une obligation de rapporter les progrès sera ajoutée aux exigences en matière de présentation de rapports trimestriels sur les SLD. Conséquemment à cet examen, la Direction pourrait avoir besoin de faire une demande de financement dans le prochain budget pour qu'un ETP centralisé remplisse ce rôle.

Recommandation 8

Que la Direction revoie ses politiques de santé et de sécurité pour les aligner sur le règlement sur les soins de santé, afin de s'aider à donner une réponse plus succincte à une inspection du ministère du Travail et de s'assurer qu'elle satisfait aux exigences en matière d'exploitation.

Réponse de la direction

La direction est d'accord avec cette recommandation. La Division de la santé et de la sécurité au travail aidera la DSLD à examiner ses politiques de santé et de sécurité avant la fin du deuxième trimestre de 2009, afin de parvenir à mieux les aligner sur le règlement sur les soins de santé.

Recommandation 9

Que l'efficacité des méthodes de communication des changements aux politiques soit mesurée et que l'accès en ligne aux politiques par le personnel soignant soit envisagé comme étant une possibilité d'accroître l'accessibilité.

Réponse de la direction

La direction est d'accord avec cette recommandation. L'accès en ligne aux politiques et aux procédures est en vigueur depuis 2007. L'efficacité de la communication des changements aux politiques est évaluée dans le cadre de l'examen annuel de conformité réalisé par le ministère de la Santé et des Soins de longue durée, ainsi que par le processus d'accréditation aux SLD ayant lieu tous les trois ans. Un outil d'évaluation interne sera analysé et pris en considération au troisième trimestre de 2009.

Recommandation 10

Que les changements aux politiques fassent l'objet de discussions et qu'un procès-verbal soit rédigé de façon uniforme aux comités appropriés.

Réponse de la direction

La direction est d'accord avec cette recommandation, et confirme qu'il s'agit d'une politique courante. Selon les politiques et les procédures de la Direction (référence nº 700:02 Manuel des politiques et des procédures), il appartient aux équipes fonctionnelles d'examiner les changements aux politiques de façon uniforme et de les consigner. Le mandat des équipes fonctionnelles a fait l'objet d'une révision au premier trimestre de 2009 et la responsabilité particulière concernant l'examen des politiques et des procédures sera documentée en vue de favoriser l'uniformité de la pratique.

Recommandation 11

Que la Direction élabore une politique uniforme concernant les protocoles de réunion et les pratiques de conservation des dossiers, notamment le format standard de l'ordre du jour d'une réunion, un modèle de procès-verbal à utiliser pour toutes les réunions et un calendrier principal affichant les différents comités prévus pour l'année, distribué à titre de référence.

Réponse de la direction

La direction est d'accord avec cette recommandation. Pour satisfaire aux exigences en matière d'accréditation, tous les comités de la DSLD ont reçu un mandat. Le dernier examen a été achevé en 2007. Au premier trimestre de 2009, la DSLD examinera l'usage fait des modèles de référence au sein de la Direction par rapport à celui fait dans les foyers. Elle envisagera l'élargissement du calendrier principal des foyers pour en faire un calendrier principal de la Direction. En conséquence de cet examen, la Direction devra possiblement faire une demande de financement dans le prochain budget pour un ETP afin de satisfaire cette fonction.

Recommandation 12

Que la Direction adopte la pratique employée à Champlain ayant trait au « Journal interne des soins infirmiers ».

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. Il existe des modèles pour la Direction et d'autres pour les foyers à l'intention du personnel, ainsi que des bulletins pour les résidents et les familles. La pratique en vigueur à Champlain constitue un détournement de la politique de la Direction et une duplication du travail. Cette pratique représente une incohérence dans les communications à l'intention du personnel, et le directeur de la Direction aimerait la voir cesser d'ici au quatrième trimestre de 2008. Les éléments du bulletin de Champlain seront intégrés aux modèles de références. Le processus nécessaire sera documenté à l'intérieur d'un programme complet de communication sur les soins de longue durée destiné au personnel.

Recommandation 13

Que la Direction revoie ses pratiques en matière d'achats pour assurer qu'une séparation de fonctions, qu'une documentation et que des processus de règlement appropriés sont mis en place.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD et les Services financiers ont effectué un examen des pratiques d'achats de la direction et ont mis en place une séparation appropriée de fonctions ou des mesures d'atténuation.

Recommandation 14

Que la Direction revoie son utilisation des cartes d'approvisionnement et des processus d'approbation afin d'assurer sa conformité à la politique d'achats de la Ville, notamment l'obligation, pour tout détenteur de carte qui permet à d'autres personnes de porter les frais sur sa carte de fournir une autorisation écrite à cet effet.

Réponse de la direction

La direction est d'accord avec cette recommandation. Comme mentionné dans les politiques et les procédures municipales en matière de carte d'approvisionnement, les détenteurs de carte n'ont pas le droit de partager leur carte avec d'autres personnes sans avoir préalablement obtenu une autorisation écrite de la part du directeur, en vue de répondre aux besoins opérationnels du Service. La DSLD s'est conformée à cette procédure, puisque l'équipe de direction a présenté une autorisation écrite au responsable du magasin pour que les commandes soient passées en son nom. Afin de réduire au minimum tout risque futur additionnel, la Direction a mis en application une politique interne stipulant que toutes les commandes passées par le responsable du magasin seront traitées en fonction de sa carte d'achat. Les éléments imputés à la carte seront ensuite rapprochés et approuvés chaque mois par le gestionnaire du responsable du magasin et les Services financiers, comme stipulé dans les procédures en matière de carte d'achat.

Le vérificateur général a également noté dans le rapport de vérification que les éléments étaient achetés sans présentation de prix concurrentiels. Ces prix concurrentiels n'étaient pas nécessaires puisqu'il s'agissait d'achats urgents de faible valeur monétaire.

La DSLD a mis en place en 2007 un processus d'achats en commun à l'aide d'un regroupement de demandes pour les processus de soumission dans tous les foyers. L'achat de fournitures médicales et de services alimentaires et environnementaux est coordonné par l'entremise d'offres permanentes.

Recommandation 15

Que la Ville achève les procédures de la boîte à outils des gestionnaires, qu'elle réunisse les différents manuels en un seul cartable clé, et qu'elle mette à jour le site intranet Ozone.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. La boîte à outils des gestionnaires de la DSLD visait à être un outil d'orientation pour les nouveaux gestionnaires de la DSLD. Il s'agit d'un manuel de référence, non d'un manuel de politiques et de procédures, et il dirige les gestionnaires vers Ozone pour qu'ils y puisent différents types de renseignements. La boîte à outils est mise à jour de façon régulière, eau fur et à mesure que les nouveaux renseignements sont transmis par courriel aux gestionnaires. Il appartient à chaque gestionnaire d'insérer l'information révisée dans son manuel respectif. Ce processus sera revu, et une réaffectation de cette tâche au même centre de responsabilité aux fins de révisions des autres manuels de procédures et de politiques de chaque foyer sera envisagée. L'échange des boîtes à outils s'est répandu à l'échelle du Service. L'étendue des pouvoirs de la DSLD ne va pas jusqu'à faire de cette boîte à outils une ressource municipale.

Recommandation 16

Qu'un processus normalisé de planification du travail soit établi dans toute la Direction afin de faire une synthèse du cadre de planification à court et à long terme, et que ce processus soit aligné sur les cadres de planification de la Ville et des Services communautaires et de protection en plus de comprendre une stratégie de présentation de rapports et de communication.

Réponse de la direction

La direction est d'accord avec cette recommandation, et confirme qu'il s'agit d'une politique courante. Depuis 2005, la DSLD a recours à une méthode de fiche de pointage équilibrée pour la planification du travail. Chaque année, la Direction examine les directives et les priorités de la Ville et celles des Services, et les intègre à la planification ayant trait à la Direction. Par exemple, en 2008, la DSLD a révisé la fiche de pointage équilibrée pour tenir compte de la directive de la Ville concernant l'excellence des services, ainsi que la directive des Services communautaires et de protection relative au service à la clientèle.

La planification stratégique de la DSLD et son processus d'élaboration des plans de travail, couplés à la révision des mesures de rendement, sont élaborés sous forme collective chaque automne. Cette étape est suivie de l'élaboration des plans de travail axés sur les foyers, qui tiennent compte des priorités majeures de la DSLD. La Direction dispose d'un processus de préparation de rapports trimestriels de l'état d'achèvement de son plan de travail. Ces renseignements sont transmis lors de réunions trimestrielles de la Direction et des réunions

générales avec le personnel qui sont tenues tous les mois. Ils sont également communiqués en tant que composant continu du processus d'accréditation en soins de longue durée. Les modèles spécifiques à utiliser seront ajoutés à titre de documents d'appui à la politique et à la procédure 700:34 : Gestion de la qualité, afin de rehausser l'uniformité des modèles de plan de travail.

Recommandation 17

Que la Direction et l'USF élaborent un mécanisme uniforme d'analyse des exigences en matière de report de la dotation de postes, ou gapping, en rapport avec le modèle de prestation des services et les indicateurs de qualité afin qu'il soit possible d'évaluer les répercussions de la pratique sur les résidents.

Réponse de la direction

La direction est d'accord avec cette recommandation. Le Comité de la haute direction a approuvé une nouvelle politique municipale de réserve pour postes vacants, qui fixe le taux de « gapping » à 1,6 % par service. La DSLD, les Services financiers et les Ressources humaines amélioreront leurs rapports actuels sur le gapping en vue de faire une meilleure analyse des écarts pour permettre l'évaluation des indicateurs de qualité, comme la répercussion de la politique sur la prestation des services. Cette mesure sera mise en place au quatrième trimestre de 2009.

Recommandation 18

Que la Direction et l'USF élaborent une politique d'hébergement privilégié et les procédures y étant associées, à partager avec le Centre d'accès aux soins communautaires (CASC) en vue d'apporter des éclaircissements et d'offrir une voie de communication visant à obtenir d'autres améliorations quant au résultat net tiré des recettes privilégiées.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. La DSLD dispose actuellement de politiques et de procédures visant à aviser le Centre d'accès aux soins communautaires dès que des lits se libèrent. Cette politique a été transmise au CASC pour assurer l'optimisation de l'hébergement privilégié. Pour ce faire, il faut que le type d'hébergement disponible (privilégié ou de base) soit déterminé au moment de l'avis.

La DSLD se conforme au règlement 39.0.1 de la *Loi sur les foyers pour personnes âgées et les maisons de repos* qui stipule que « a home shall ensure that no more than 60 per cent of the bed capacity of the home is set aside as preferred accommodation (un foyer doit s'assurer qu'au plus 60 % de sa capacité en lits soit réservée à l'hébergement privilégié) ». Pour l'ensemble des foyers, les recettes tirées de l'hébergement privilégié représentaient 96 % en 2006, 97 % en 2007 et 99 % à la fin d'août 2008.

Recommandation 19

Que, dans le cadre de la mise en œuvre de Goldcare, la Direction et l'USF créent de nouveaux rapports ou vues à partir de Goldcare afin de fournir une version électronique des rapports de recensement dans laquelle apparaîtraient des indicateurs facilitant la tâche des travailleurs sociaux en ce qui a trait aux déménagements de lit en vue d'optimiser les recettes tirées de l'hébergement privilégié.

Réponse de la direction

La direction est d'accord avec cette recommandation. De nouveaux rapports ont été élaborés et mis en application en vue d'aider les travailleurs sociaux à s'assurer que les recettes tirées de l'hébergement privilégié, qui sont actuellement optimisées, continuent de l'être dans l'avenir.

Recommandation 20

Que la Direction et l'USF confirment régulièrement leurs connaissances des dépenses admissibles pour chaque enveloppe et analysent ces coûts à la verticale et à l'horizontale (entre les foyers, d'une année à l'autre, et en comparaison avec d'autres foyers).

Réponse de la direction

La direction est d'accord avec cette recommandation. Le personnel des Services financiers et de la DSLD a conscience de l'admissibilité des dépenses à l'intérieur de chaque enveloppe de financement et il la comprend. Des vérifications annuelles des dépenses sont réalisées par des tiers afin de s'assurer de la conformité à certaines lignes directrices particulières du Ministère. La Direction effectuera plus de rapports et d'analyses des dépenses comprises dans les enveloppes de financement, en collaboration avec les Services financiers, dès le deuxième trimestre de 2009.

Recommandation 21

Que la Direction élabore un plan global du projet de mise en œuvre de Goldcare comportant les étapes déterminantes et les éléments livrables, ainsi qu'une présentation régulière de rapports sur la situation, les résultats et les activités de formation, et des précisions sur le nombre d'années de la période de récupération du système.

Réponse de la direction

La direction est d'accord avec cette recommandation; un plan du projet, élaboré par la Direction, les STI et le fournisseur, est actuellement en place.

Un plan du projet a été mis en place dès le début du projet pour une mise en œuvre et un développement continu. Un comité directeur de la Direction et un groupe d'utilisateurs ont été créés après la mise en œuvre (T4 2008). Ces équipes

se rencontrent sur une base trimestrielle et mensuelle, selon leur mandat respectif, en vue de régler les problèmes émergents et de déceler les nouvelles possibilités que présentent les mises à jour de la version du logiciel. Des rapports de situation sont fournis à l'équipe de direction de la DSLD en tant qu'éléments permanents de l'ordre du jour.

Recommandation 22

Que la Direction étalonne sa mesure de composition de la clientèle avant la mise en œuvre de Goldcare, y compris la subvention par rapport à celle suivant la mise en œuvre de Goldcare.

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'il s'agit d'une pratique courante. La DSLD a fait un suivi de la mesure et de l'indice de composition de la clientèle (MCC et ICC) pour les quatre foyers au cours des sept dernières années, et a continué de le faire après la première phase de mise en œuvre de Goldcare, achevée en mai 2008. Administrateurs et gestionnaires des soins aux résidents reçoivent cette documentation chaque année. Il est à noter que, à compter du quatrième trimestre de 2009, l'ICC ne sera plus utilisé pour l'évaluation des résidents des foyers de SLD. Cette conversion du programme aura lieu à la phase 6 de la conversion provinciale au Resident Assessment Instrument-Minimum Data Set (RAI-MDS) (minimum de données standardisées [MDS] de la méthode d'évaluation RAI). Les foyers de la Ville participeront au programme et ne recevront plus de résultats concernant le MCC et l'ICC.

Recommandation 23

Que la Direction fasse parvenir à l'USF une copie de ses demandes au Fonds d'aide à la prestation des soins spéciaux afin d'améliorer les pratiques liées aux comptes débiteurs et de permettre un rapprochement adéquat.

Réponse de la direction

La direction est d'accord avec cette recommandation. Un processus de rapprochement des demandes au Fonds d'aide à la prestation de soins spéciaux et des revenus du Ministère a été élaboré et mis en application au cours de la première phase de mise en œuvre de Goldcare, achevée en mai 2008.

Recommandation 24

Que la Direction compare la politique relative au Fonds d'aide à la prestation de soins spéciaux à la pratique interne afin de déceler toute possibilité additionnelle de récupération des coûts du foyer.

Réponse de la direction

La direction est d'accord avec cette recommandation. La Direction effectue annuellement cette pratique pour s'assurer de l'optimisation de toutes les possibilités de récupération des coûts. Une documentation de cette pratique sera intégrée à l'examen du mandat des équipes fonctionnelles, au premier trimestre de 2009.

Recommandation 25

Que la Direction coordonne ses soumissions au programme de subventions et qu'elle aide la direction des foyers à répondre.

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'il s'agit d'une pratique courante. La pratique en cours consiste à coordonner les soumissions sur la subvention à l'équipe de direction de la DSLD. Son entrée en vigueur, en 2004, visait à optimiser la capacité des foyers à accéder aux fonds nouvellement annoncés par l'entremise de la stratégie provinciale de soins infirmiers. L'équipe de direction de la DSLD discute des occasions de financement à venir; un administrateur est nommé pour coordonner la demande au nom de la Direction, et une demande centrale est présentée. Dans certains cas, le ministère de la Santé et des Soins de longue durée exige une présentation par foyer et cette exigence est évaluée pour chaque nouvelle possibilité de financement. Ce processus perdure depuis 2004 et sert maintenant aux autres demandes centrales, comme la recherche, compte tenu du succès remporté par la Direction en matière d'accès aux fonds grâce à un processus centralisé.

Recommandation 26

Que la Direction détermine l'à-propos des coûts affectés, documente la méthode d'affectation des coûts d'administration et s'assure que la documentation est à la disposition au fin de vérification.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les coûts sont affectés conformément aux lignes directrices du Rapport d'information financière (RIF). La DSLD documentera la méthodologie d'affectation et la conservera dans ses dossiers à l'intention de son personnel et des exigences de vérification future. Cette mesure sera mise en place dès le troisième trimestre de 2009.

Recommandation 27

Que la Direction, de concert avec l'USF, élabore des politiques et des procédures pour la gestion des comptes en fiducie qui prennent en considération les normes du programme du MSSLD, de même que les lois et les règlements provinciaux, et

qui mentionnent clairement les responsabilités et l'imputabilité de la Direction et de l'USF.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD et l'USF se conforment actuellement aux politiques et aux procédures régies par la *Loi sur les foyers pour personnes âgées et les maisons de repos*. Un tiers effectue chaque année une vérification des états financiers afin de confirmer la conformité de la Direction à certaines lignes directrices particulières du Ministère.

Les Services financiers et la DSLD officialiseront les politiques et aux procédures actuelles et les documenteront avant le quatrième trimestre de 2009.

Recommandation 28

Que la Direction mette à jour son entente relative à l'admission pour y intégrer l'imputation à la fiducie des frais d'hébergement ainsi que tous les autres frais autorisés et paraphés par les résidents.

Réponse de la direction

La direction est d'accord avec cette recommandation. Avant cet examen, l'entente relative à l'admission énumérait les services fournis par la DSLD acceptés en bloc par le résident ou en vertu d'une procuration. Cette entente a fait l'objet d'une mise à jour et comprend maintenant des cases voisinant chaque service, qui doivent être paraphées au moment de l'admission.

Recommandation 29

Qu'un processus d'examen annuel soit mis en place pour chaque résident/famille en vue de s'assurer que les frais imputés à la fiducie ont d'abord été convenus.

Réponse de la direction

La direction est d'accord avec cette recommandation. À l'heure actuelle, chaque résident/famille reçoit un relevé de compte mensuel présentant le solde restant, les frais imputés et le solde de clôture de leur compte en fiducie. De plus, dès la clôture de l'exercice 2008, les Services financiers fourniront chaque année un exposé récapitulatif aux fins d'examen.

Recommandation 30

Que, au moins une fois par année, un sondage soit réalisé auprès des résidents et des familles concernant leur expérience financière en vue d'évaluer le service à la clientèle de l'USF.

Réponse de la direction

La direction est d'accord avec cette recommandation. Cette mesure fait partie du sondage annuel sur la satisfaction des résidents réalisé depuis 2001 dans le cadre

du processus de préparation de rapports pour l'Initiative d'analyse comparative des services municipaux de l'Ontario (IACSM).

Recommandation 31

Que la Direction revoie la politique en matière d'intérêt des comptes en fiducie afin de déterminer s'il existe des possibilités d'augmentation des intérêts créditeurs pour les résidents.

Réponse de la direction

La direction est d'accord avec cette recommandation. La *Loi sur les foyers pour personnes âgées et les maisons de repos* (règlement 637) limite le type d'investissements que les comptes en fiducie peuvent engager, puisqu'elle exige que les résidents puissent disposer de leurs fonds en tout temps. Les comptes en fiducie des résidents satisfont aux exigences stipulant que les fonds doivent être disponibles sur demande, ils génèrent actuellement un rendement à un taux préférentiel inférieur à 1,75 %, soit le taux le plus concurrentiel sur le marché, comme l'a confirmé l'institution financière de la Ville.

Recommandation 32

Que la Direction revoie le pouvoir de signature lié à la fiducie et la pratique de fermeture des comptes en fiducie, et qu'elle mette en place des mesures de contrôle plus rigoureuses pour les chèques.

Réponse de la direction

La direction est d'accord avec cette recommandation. Un pouvoir de signature des comptes en fiducie a été instauré et fait partie de l'entente relative à l'admission.

Le vérificateur général mentionne que des améliorations peuvent être apportées aux mesures de contrôle pour les chèques émis parce que ces derniers étaient à la vue de tous. Les Services financiers œuvrent dans un espace sécurisé, et les chèques sont conservés dans un emplacement verrouillé lorsqu'ils ne sont pas utilisés.

Recommandation 33

Que la Direction revoie son cadre de responsabilités en ce qui concerne les exigences financières et qu'elle passe à une méthode intégrée de budgétisation, de concert avec les Services communautaires et de protection et toute la Ville.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. Le vérificateur général a conclu que les Services financiers fournissent des lignes directrices et des paramètres pour les budgets et que cette pratique réduit les possibilités de la Direction de prendre des décisions. Pour le budget, la direction reçoit des lignes

directrices et des paramètres du Conseil municipal, non des Services financiers. La hiérarchie de la Direction établit les cibles annuelles qui sont ensuite examinées au niveau de la Direction/des Services avant d'être présentées dans les prévisions budgétaires.

Le Plan financier à long terme permet également à la Direction de déceler les besoins obligatoires des Opérations municipales et de toute la Ville.

Recommandation 34

Que la Direction effectue un examen annuel en vue d'évaluer les économies possibles ainsi que les occasions de recettes.

Réponse de la direction

La direction est d'accord avec cette recommandation. L'examen annuel des économies est pratique courante. Le premier examen, effectué en 2007, faisait partie du processus lié au Programme d'examen des processus en vigueur dans les directions, et comportait une analyse comparative externe. La DSLD conclut actuellement son deuxième examen annuel par l'entremise du processus d'examen stratégique des directions, qui se terminera à la fin du T4 2008.

Recommandation 35

Que la Direction passe à des budgets pluriannuels tenant compte des coûts du cycle de vie et du coût à long terme des immobilisations, ainsi que de la conformité au CCSP.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD, conjointement avec toutes les directions de la Ville, participe au processus de budget annuel. La budgétisation pluriannuelle des immobilisations comprenant l'établissement des coûts liés au cycle de vie est en vigueur depuis la fusion de la Ville; des budgets de fonctionnement pluriannuels sont réalisés depuis 2008.

Recommandation 36

Que la préparation des budgets de fonctionnement de la Direction continue de se faire sur la base de résidents par jour, et que la surveillance des résultats des dépenses et des recettes soit faite sur cette base.

Réponse de la direction

La direction est d'accord avec cette recommandation. La pratique actuelle consiste à préparer des rapports de fonctionnement sur la base de résidents par jour, ce qui fait en sorte que les résultats sont surveillés pour les dépenses et les recettes.

Recommandation 37

Que la préparation des budgets d'immobilisations de la Direction soit effectuée sur la base du coût lié au cycle de vie afin de s'assurer que tous les coûts sont intégrés à chaque projet d'immobilisation.

Réponse de la direction

La direction est d'accord avec cette recommandation. Bien que la DSLD reçoive une dotation fixe pour les immobilisations mineures, elle utilise une approche relative au cycle de vie liée au programme d'entretien préventif des foyers pour établir les priorités de remplacement des immobilisations dans les quatre foyers, ce qui comprend, entre autres, l'équipement médical, les mobiliers, l'équipement de cuisine et autres.

Recommandation 38

Que la Direction et l'USF collaborent en vue de rédiger des rapports utiles et opportuns sur les écarts.

Réponse de la direction

La direction est d'accord avec cette recommandation. La pratique actuelle consiste à fournir chaque mois des rapports sur le fonctionnement et les immobilisations, ainsi que sur les écarts imprévisibles, selon les besoins. Les Services financiers continueront d'examiner et de rédiger des rapports présentés pour confirmer leur efficacité.

Recommandation 39

Que la Direction, de concert avec l'USF, élabore un cadre de contrôle interne comportant un éventail complet de politiques de contrôle, notamment des politiques en matière de comptes débiteurs, de stocks et d'immobilisations corporelles.

Réponse de la direction

La direction est d'accord avec cette recommandation. Des politiques municipales, en cours d'élaboration sur une base permanente, font partie du cadre de contrôle financier. Des politiques portant sur les comptes débiteurs existent, mais ne sont pas entièrement documentées. La mise en place d'une documentation appropriée sera réalisée avant le troisième trimestre de 2009. En ce qui a trait aux immobilisations corporelles, la Direction a remis à plus tard l'examen des actifs immobilisés jusqu'à l'élaboration du nouveau protocole en matière d'immobilisations corporelles. Une fois celui-ci mis en œuvre, les comptes et la ventilation appropriés seront possibles. Les Services financiers se conformeront à l'exigence 3150 du CCSP qui entre en vigueur le 1er janvier 2009, pour la présentation des rapports sur les états financiers de 2009, à la mi-année 2010.

Recommandation 40

Que la Direction revoie son processus de paie et d'établissement des horaires afin de déterminer si les cartes d'accès peuvent faciliter le rapprochement de la paie.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD et les Ressources humaines reverront le processus de paie et d'établissement des horaires afin de déterminer si les cartes d'accès facilitent le rapprochement de la paie avant le troisième trimestre de 2009.

Recommandation 41

Que la Direction collabore avec l'USF en vue d'améliorer la présentation de rapports financiers et de s'assurer de sa conformité au CCSP.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les Services financiers continueront de présenter des rapports mensuels sur le fonctionnement et les immobilisations, ainsi que des rapports sur les écarts imprévisibles, selon les besoins. Les Finances se conformeront à l'exigence 3150 du CCSP, qui entre en vigueur le 1er janvier 2009, pour la présentation des états financiers de 2009, à la mi-année 2010. Les Services financiers sont actuellement en train d'élaborer de nouvelles normes en matière de présentation de rapports, et la formation du personnel visé est commencée.

Recommandation 42

Que la Direction revoie la nécessité d'employer un coiffeur à temps plein dans chaque foyer et envisage la possibilité de recourir à un service contractuel (respectant la convention collective).

Réponse de la direction

La direction est d'accord avec cette recommandation. La convention collective de la Ville comporte une disposition qui protège ce service de l'impartition. La DSLD et les Ressources humaines exploreront avec le syndicat la possibilité de soustraire ce service aux dispositions de la convention collective relatives à l'impartition.

Recommandation 43

Que la Direction revoie ses coûts d'alimentation et ses taux de récupération pour la Popote roulante, les repas familiaux et autres, afin d'établir les taux appropriés.

Réponse de la direction

La direction est d’accord avec cette recommandation. Un examen annuel et un processus de gestion des contrats sont en place. Le processus annuel comprend un examen des coûts d'alimentation en soins de longue durée et tient compte des hausses provinciales du coût des aliments crus.

Recommandation 44

Que la Direction revoie ses activités de collecte de fonds en vue d’évaluer les sources possibles de recettes pour le compte des résidents.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. Les foyers n'ont pas de rôle à jouer dans la collecte de fonds. Toutefois, à compter de février 2009, le Conseil d’administration du nouveau Long Term Care Prosperity Fund (fonds de la prospérité des soins de longue durée) comportera des représentants du personnel de la DSLD. Ce Fonds est une nouvelle initiative à visée communautaire ayant pour but d’obtenir des fonds communautaires pour les programmes supplémentaires dans le domaine des soins de longue durée.

Recommandation 45

Que la Direction s’assure que le tout dernier formulaire d’entente relative à l’admission soit utilisé pour toutes les admissions dans les foyers.

Réponse de la direction

La direction est d’accord avec cette recommandation et veillera à se conformer à la politique actuelle qui exige l'utilisation du formulaire mis à jour, disponible par l’entremise d’Ozone. Un processus, mis en place en 2007, fait en sorte que les ententes actuelles sont affichées dans Ozone afin de s’assurer que les formulaires d’entente relatifs à l’admission sont les mêmes dans les quatre foyers.

Recommandation 46

Que l’USF mette en place des mesures d’assurance de la qualité visant à revoir les documents d'admission envoyés par les travailleurs sociaux de chaque foyer, y compris la liste de vérification de l'admission, afin de s'assurer que la documentation est complète et que le processus annuel d'examen des dossiers administratifs des résidents avec déclarations complètes de fiducie et d’hébergement soit effectué.

Réponse de la direction

La direction est d’accord avec cette recommandation. Un processus a été mis en place en vue de s’assurer que les dossiers administratifs des résidents sont complets. De même, les déclarations de fiducie et d'hébergement seront mises dans les dossiers chaque année.

Recommandation 47

Que la Direction élabore de meilleures procédures relatives aux cartes d'accès, surtout en ce qui a trait à l'émission des cartes aux résidents/familles et aux processus pour l'annulation hors des heures d'ouverture.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. Les procédures actuellement en place pour les cartes d'accès sont efficaces. De plus, il existe un processus pour l'annulation immédiate des cartes hors des heures d'ouverture. La procuration pour soins de la personne donne les pouvoirs nécessaires pour communiquer avec l'administrateur du foyer en vue de modifier verbalement les heures d'accès d'une carte en situation de soins au terme de la vie. L'infirmière chef de l'établissement a l'autorité de communiquer avec l'administrateur ou son remplaçant désigné pour autoriser une modification relative à l'accès de la carte hors des heures d'ouverture, conformément aux politiques et aux procédures (référence n° 750:25 Cartes d'accès – Familles et résidents). Cette politique sera revue avec le personnel au deuxième trimestre de 2009.

Recommandation 48

Que les foyers donnent accès aux vestibules des immeubles sans compromettre la sécurité de l'immeuble.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD a déjà étudié cette possibilité de concert avec les Services de sécurité, et la reverra au deuxième trimestre de 2009. Pour atténuer les risques potentiels d'exposition des résidents à la chaleur ou au froid, une carte d'accès est nécessaire pour quitter les foyers, ce qui réduit la probabilité qu'un résident soit incapable d'entrer dans l'immeuble. De plus, il y a actuellement une sonnette de porte qui sonne à la réception ou qui fait sonner le téléphone cellulaire de l'infirmière en chef, favorisant de ce fait un accès dans les plus brefs délais.

Recommandation 49

Que la Direction mette en application des politiques concernant l'accès des fournisseurs dans des aires non sécurisées et/ou non surveillées de l'immeuble, y compris un avertissement donné à la réception que des fournisseurs sont dans l'immeuble.

Réponse de la direction

La direction est d'accord avec cette recommandation et s'assurera de sa conformité à la politique actuelle. La pratique actuelle fait en sorte que le personnel accompagne les fournisseurs non autorisés, conformément aux

politiques et aux procédures (référence n° 700:21 Sécurité – Vendeurs, maîtres des travaux, entrepreneurs spécialisés).

Recommandation 50

Que la Direction examine son mandat de santé et de sécurité à la lumière des clauses de la *Loi sur la santé et la sécurité au travail* portant sur les inspections du lieu de travail.

Réponse de la direction

La direction est d'accord avec cette recommandation. Un examen complet, réalisé en 2007, a révélé que les pratiques de la DSLD étaient conformes. Dans le cadre du processus d'examen régulier, Santé et Sécurité au travail révisera le mandat de concert avec la DSLD et fera des recommandations et/ou une révision complète, selon les besoins, avant la fin du deuxième trimestre de 2009.

Recommandation 51

Que, durant la prochaine ronde de planification stratégique pour les Services communautaires et de protection, la Direction joue un rôle plus actif afin de s'assurer que le plan des Services tienne compte de sa vision.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. La DSLD participe activement à la planification des Services et juge que le plan d'Opérations municipales tient adéquatement compte de sa vision. Depuis 2001, la DSLD a mis un fort accent sur la satisfaction des résidents/de la clientèle. Les plans des Services et de la Ville en tiennent tous deux compte.

Recommandation 52

Que le processus de planification opérationnelle, les mécanismes de présentation de rapports et le format du plan d'affaires utilisés par la Direction et les foyers soient normalisés, y compris les examens trimestriels des plans d'affaires et des Services et les analyses des écarts, en vue d'apporter rapidement des mesures correctives.

Réponse de la direction

La direction est d'accord avec cette recommandation. Ce processus est déjà en place et obtient l'appui de l'USF depuis 2006. Il sera documenté avant le troisième trimestre de 2009 afin d'assurer une pratique uniforme.

Recommandation 53

Que la Direction continue d'effectuer une analyse annuelle des indicateurs des besoins à partir des activités de gestion de la qualité afin de s'assurer de la pertinence des indices de la fiche de pointage équilibrée.

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'il s'agit d'une pratique courante. Un processus d'examen annuel est en place depuis que la DSLD a adopté la méthode de fiche de pointage équilibré, en 2005. La Direction continue d'effectuer un examen annuel des indicateurs dans le cadre du processus existant, qui comprend la participation de tous les niveaux de gestion des soins de longue durée. Tous les gestionnaires ont l'occasion de soulever une question litigieuse concernant les indicateurs lors des réunions mensuelles de leur équipe fonctionnelle et des réunions trimestrielles de la DSLD, et au cours de l'examen formel réalisé chaque année dans le cadre du processus de fiche de pointage équilibré. Les soumissions peuvent être présentées sous forme écrite ou verbale. Au cours de l'examen des mandats, au quatrième trimestre de 2009, une exigence documentée concernant la soumission écrite des indicateurs sera envisagée.

Recommandation 54

Que soit établie la pratique de génération de rapports modèles pour le personnel au cours de la mise en œuvre de Telestaff.

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'elle fait partie du plan de mise en œuvre. C'est compris dans le plan de mise en œuvre par étapes de Telestaff. Les foyers qui ont déjà mis le logiciel en œuvre reçoivent actuellement des rapports. Les mécanismes de présentation régulière de rapports à la direction seront tout à fait établis avant le troisième trimestre de 2009.

Recommandation 55

Que la Direction évalue le risque d'absence du seul membre du personnel responsable des indicateurs de la fiche de pointage équilibrée et réagisse à l'aide d'un plan d'urgence approprié.

Réponse de la direction

La direction n'est pas d'accord avec cette recommandation. Cette fonction n'est pas le fait d'un seul membre du personnel. Tous les gestionnaires ont la responsabilité de saisir les données de leur programme dans les modèles de fiche de pointage équilibrée, et un gestionnaire est chargé de superviser le programme. À ce jour, cette approche, qui est revue chaque année dans le cadre du processus de planification stratégique et opérationnelle, n'a posé aucun problème.

Recommandation 56

Que les rôles et les responsabilités respectives de l'USF, de la GBI, des Services aux employés, du personnel de la Direction et de celui des foyers soient

documentés dans une entente de service, avec les normes et les attentes relatives au rendement.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les ententes sur les niveaux de service existent déjà, mais elles seront mises à jour afin de tenir compte des rôles et des responsabilités, de même que des normes et des attentes relatives au rendement.

Les Ressources humaines travailleront de concert avec la DSLD à la mise à jour de leur ententes sur les niveaux de service avant la fin du deuxième trimestre de 2009. La GBI, en collaboration avec la DSLD, amorcera des travaux d'élaboration d'une convention de services au cours du troisième trimestre de 2009. Pour ce qui est de l'USF, les rôles et les responsabilités seront documentés au fil de la restructuration organisationnelle, qui se terminera avant le premier trimestre de 2010.

Recommandation 57

Que le programme d'orientation offert aux nouveaux conseillers municipaux comprenne une partie mentionnant leurs responsabilités en vertu de la *Loi sur les foyers de soins de longue durée* et la *Loi sur la santé et la sécurité au travail*.

Réponse de la direction

La direction est d'accord avec cette recommandation. Dans le prochain programme d'orientation des nouveaux conseillers, la DSLD reverra les renseignements fournis et s'assurera que les documents sont mis à jour en vue de tenir compte de toute modification apportée à la nouvelle *Loi sur les foyers de soins de longue durée* d'ici au troisième trimestre de 2010. De plus, Santé et sécurité au travail (SST) intégrera un survol des responsabilités de l'employeur en vertu de la *Loi sur la santé et la sécurité au travail*.

Recommandation 58

Que des examens du rendement soient réalisés régulièrement afin d'évaluer les besoins en formation, d'établir de nouveau les engagements et de fixer les objectifs pour les années à venir.

Réponse de la direction

La direction est d'accord avec cette recommandation. La pratique courante consiste à entreprendre des examens annuels du rendement des employés à temps plein appartenant à la section locale 503 du SCFP et à l'IPPM, et des examens tous les deux ans pour les employés à temps partiel et occasionnels appartenant à la section locale 503 du SCFP. Une base de données sur le rendement du personnel est tenue à jour afin de veiller à ce que les cibles soient atteintes et à ce que l'on présente aux gestionnaires un rapport mensuel

énumérant les évaluations du rendement à recevoir pour le mois. Les évaluations du rendement des superviseurs et des gestionnaires comprennent une attente convenue avec le personnel concernant l'achèvement de l'évaluation du rendement, et les résultats sont surveillés tout au long du processus. Un projet pilote, amorcé au foyer Armstrong au quatrième trimestre de 2008, visait à soumettre la portion du plan de formation et de perfectionnement de toutes les évaluations du rendement de tout le personnel au coordonnateur de la formation et du perfectionnement afin de faciliter l'analyse des types de problèmes décelés dans les plans de perfectionnement. Des changements seront apportés dans tous les foyers au premier trimestre de 2010 en fonction des résultats obtenus dans ce projet pilote.

Recommandation 59

Que, après la mise en œuvre de Telestaff, la Direction et l'USF travaillent de concert à la production de rapports de dotation afin d'évaluer l'efficacité du modèle de prestation des services.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD, les Services financiers et les Ressources humaines rédigeront des rapports visant à évaluer l'efficacité du modèle de prestation des services après la mise en œuvre de Telestaff, au troisième trimestre de 2009.

Recommandation 60

Que les plans et les initiatives de gestion de la qualité fassent l'objet de discussions régulières au sein de la Direction en vue d'établir des exigences normalisées et de favoriser l'uniformité parmi les foyers.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les plans de gestion de la qualité ont été révisés chaque trimestre au cours des réunions de l'équipe de direction de la DSLD et chaque année, depuis 2007, de concert avec les gestionnaires des foyers. Le programme de gestion de la qualité, documenté dans les politiques et procédures 700:34, a été modifié au premier trimestre de 2009 afin de tenir compte des changements apportés au processus de présentation de rapports du programme de fiche de pointage équilibrée.

Recommandation 61

Que la Direction et ses foyers continuent d'utiliser les indicateurs de gestion de la qualité pour apporter des précisions à leurs examens des politiques et des pratiques, qu'un examen systématique des indicateurs soit réalisé en vue de s'assurer qu'ils sont toujours pertinents pour l'organisme en tant que mesures

facilitant la surveillance de la qualité des soins et des services, et d'atténuer les possibilités de risque inacceptables.

Réponse de la direction

La direction est d'accord avec cette recommandation.

Les indicateurs de qualité font l'objet d'un examen trimestriel, et les plans de travail sont établis chaque année, en plus de faire partie du processus d'accréditation de trois ans. Le programme de gestion de la qualité, documenté dans les politiques et procédures 700:34, a été modifié au premier trimestre de 2009 afin de tenir compte des changements apportés au processus de présentation de rapports du programme de fiche de pointage équilibrée.

Recommandation 62

Que la Direction continue d'analyser des méthodes efficientes en vue d'accéder aux pratiques exemplaires de l'industrie et de planifier la mise en application de ces pratiques dans tout l'organisme.

Réponse de la direction

La direction est d'accord avec cette recommandation. La DSLD effectue un examen annuel de l'efficience et participe à l'IACSM. Dernièrement, un remaniement du poste de superviseur des soins aux résidents de chaque foyer, devenu coordonnateur des pratiques exemplaires, ouvrira sur une approche sectorielle et interdisciplinaire plus générale concernant ces examens annuels et intégrera des composants comme des associations provinciales et nationales, des experts en la matière, des travaux de congrès, des analyses documentaires et des revues examinées par des pairs.

Recommandation 63

Que la Direction maintienne son implication active sur les questions liées aux personnes âgées et aux soins de longue durée dans la région et encourage les autres à en faire autant afin d'augmenter la visibilité des soins de longue durée de la Ville.

Réponse de la direction

La direction est d'accord avec cette recommandation et confirme qu'il s'agit d'une pratique courante. Depuis les quatre dernières décennies, la DSLD a dirigé des initiatives pour les personnes âgées et a participé à des partenariats dans le secteur des soins de longue durée et à des partenariats communautaires, comme Bien vieillir à Ottawa, le Conseil d'impact des aînés de Centraide, le Programme des personnes âgées, le Réseau de la démence de la région Champlain et le Comité consultatif régional sur les soins gériatriques afin de renforcer le rôle de la DSLD et de favoriser la recherche et les pratiques exemplaires au sein des foyers de soins de longue durée de la Ville. Ce rôle de leadership a

traditionnellement été la responsabilité du directeur des soins de longue durée et se prolongera, si possible, à tous les échelons du personnel et de la direction actuels.

Recommandation 64

Que la Direction revoie ses besoins en formation à la lumière des exigences obligatoires et de la pratique professionnelle.

Réponse de la direction

La direction est d'accord avec cette recommandation. La pratique actuelle sera formellement documentée sous forme de politique en vue d'en assurer l'uniformité. La formation obligatoire est revue chaque année afin de s'assurer qu'elle est à jour par rapport à la pratique courante. La formation professionnelle est revue chaque année pour s'assurer de satisfaire aux exigences réglementaires.

Recommandation 65

Que la Direction revoie les compétences et les rôles requis liés au poste de travailleur social afin de déterminer le meilleur usage de ce poste à partir des perspectives conjointes relatives à sa contribution aux soins interdisciplinaires dispensés aux résidents et au rapport coût-efficacité.

Réponse de la direction

La direction est d'accord avec cette recommandation. Ce poste est actuellement à l'étude afin d'en déterminer les éléments administratifs et les éléments tirés de l'expertise en travail social. Les résultats de l'évaluation du poste devraient être soumis avant le premier trimestre de 2010.

Recommandation 66

Que plus d'achats en commun soient effectués pour tous les foyers.

Réponse de la direction

La direction est d'accord avec cette recommandation. En 2007, la DSLD a mis en application un processus d'achats en commun par l'entremise d'un regroupement des demandes visant un processus d'offres pour l'ensemble des foyers. Les achats de fournitures médicales, de nourriture et de services environnementaux sont coordonnés par l'entremise d'offres permanentes.

Recommandation 67

Que les plans soient élaborés pour les projets Goldcare et Telestaff afin d'inclure les réalisations à ce jour, les étapes déterminantes, la formation et les éléments livrables, en vue de faciliter les processus de mise en œuvre opportune.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les Soins de longue durée ont élaboré des plans de projet pour Goldcare et Telestaff afin d'obtenir le financement initial du projet et l'appui des STI. Telestaff dispose d'un plan de mise en œuvre à étapes multiples qui sera terminé au troisième trimestre de 2009. Un comité directeur a été mis sur pied en vue de déceler les occasions et les secteurs stratégiques pour l'élaboration de politiques concernant l'utilisation permanente du système Goldcare. En outre, un groupe d'utilisateurs de Goldcare a été formé pour prêter assistance au personnel dans la résolution des problèmes courants des utilisateurs et pour déterminer les besoins additionnels de l'utilisateur en ce qui a trait aux mises à jour annuelles du logiciel.

Recommandation 68

Qu'au moment de la mise en œuvre du système Telestaff, la Direction et l'USF travaillent de concert à l'élaboration d'un calendrier régulier de rapports et d'analyses des écarts qui facilitera la tâche des gestionnaires dans l'établissement des niveaux de dotation appropriés.

Réponse de la direction

La direction est d'accord avec cette recommandation. Après la mise en œuvre de Telestaff, au troisième trimestre de 2009, la DSLD, les Services financiers et les Ressources humaines élaboreront des rapports en vue d'évaluer l'efficacité du modèle de prestation des services.

Recommandation 69

Que les différents outils de sondage soient revus régulièrement afin de s'assurer que les questions permettent d'obtenir des renseignements significatifs et utiles, et pour établir la pertinence du contenu aux fins d'amélioration des services dans tous les domaines opérationnels.

Réponse de la direction

La direction est d'accord avec cette recommandation. Les outils de sondage, comme le sondage sur la satisfaction des résidents, le questionnaire d'évaluation des besoins du personnel, le sondage sur les soins palliatifs, le sondage sur l'admission, et autres, sont revus chaque année avant d'être réutilisés. À titre d'exemple, le sondage de 2008 sur la satisfaction des résidents comportait des modifications en vue d'obtenir des renseignements plus détaillés sur certains secteurs de services particuliers pour permettre aux gestionnaires de saisir des données sur un programme donné et faciliter la modification des offres du programme.

Recommandation 70

Que la Direction et l'USF entament des discussions avec le responsable du CCSP de la Ville en vue d'évaluer les répercussions de la présentation de rapports sur les soins de longue durée dans un contexte de comptabilité d'exercice.

Réponse de la direction

La direction est d'accord avec cette recommandation. Des discussions sont déjà en cours et continueront dans le futur afin de s'assurer que les exigences 3150 du CCSP sont satisfaites avant la présentation des états financiers de 2009, à la mi-année 2010.

Recommandation 71

Que la Direction, en consultation avec la GBI, élabore un plan de gestion des actifs à long terme qui englobe un plan de remplacement avec un horizon prévisionnel minimal de 20 ans pour tous les immeubles et les équipements.

Réponse de la direction

La direction est d'accord avec cette recommandation. En sa qualité de propriétaire bailleur de la Ville, la GBI a réalisé les examens nécessaires de l'état de Carleton Lodge, du Centre d'accueil Champlain et du foyer Peter D. Clark afin d'établir un plan de renouvellement à long terme des immobilisations adapté aux étapes de leur cycle de vie et un plan complet de gestion des immobilisations des établissements de soins de santé de longue durée de la Ville. Les résultats de ces examens de l'état ont fait l'objet d'une pondération dans le plan global de renouvellement adapté aux étapes du cycle de vie pour les 20 prochaines années, et Carleton Lodge, plus précisément, a déjà bénéficié d'un investissement important. Comme il s'agit d'un nouvel établissement, l'examen de l'état du foyer Garry-J.-Armstrong sera réalisé dans cinq ans, et les résultats seront intégrés au programme global de renouvellement adapté aux étapes du cycle de vie.

Recommandation 72

Que la Direction mette en place un système de gestion des stocks, notamment de gestion des aliments et des stocks de fournitures médicales.

Réponse de la direction

La direction est d'accord avec cette recommandation.

La Ville tient résolument à protéger les immobilisations de la municipalité. Les directeurs opérationnels de la municipalité sont responsables du contrôle et de la protection des immobilisations de la Ville qu'ils utilisent pour la prestation de services; ils occupent en outre la position idéale pour harmoniser les mesures de contrôle à leurs besoins opérationnels. Il est clairement mentionné dans la section

Responsabilités de la direction du Code de conduite de la Ville que : « La direction protège les biens de la Ville et sauvegarde la confiance que le public accorde à l'administration municipale. À cette fin, elle met en œuvre tous les moyens dont elle dispose pour établir et tenir les systèmes, les méthodes et les contrôles appropriés qui lui permettent de prévenir et de détecter les cas de fraude, de vol, d'abus de confiance, de conflits d'intérêts, de discrimination et toute autre forme de méfaits ».

Des politiques municipales, déjà en place, portent sur l'actualisation, la dépréciation, la détermination, la comptabilité, l'enregistrement et la protection des immobilisations de la Ville et des stocks; elles comportent en outre une description claire des responsabilités au sein de la municipalité. La nourriture, les fournitures médicales ou autres articles consommables utilisés par la DSLD sont des éléments dépensés durant l'année; ils ne font pas partie d'une catégorie d'éléments d'actifs majeure et ne sont pas saisis dans le système d'inventaire des magasins. La grande majorité de ces fournitures et de ces matières est achetée sur une base « juste-à-temps », est passée en charge et consommée ou utilisée sur-le-champ. Ces articles sont liés aux achats effectués pour la prestation des services de soins de longue durée et ne sont pas des articles qu'il convient d'intégrer aux stocks.

La DSLD de concert avec les Services financiers reverront néanmoins les systèmes actuels et mettront en place, si nécessaire, un système de gestion des stocks, des mesures additionnelles de contrôle ou des mesures d'atténuation en vue de limiter les risques. Les besoins en matière de financement seront énoncés dans le budget de 2010. Ces mesures seront mises en place avant le troisième trimestre de 2010.

Recommandation 73

Que la Direction et ses coordonnateurs de l'éducation revoient les cibles relatives à la participation en ce qui a trait à la formation en milieu de travail et qu'ils analysent les pratiques exemplaires élaborées par d'autres foyers en vue de faciliter les stratégies intégrées et rentables pour la prestation annuelle des séances de formation obligatoire du MSSLD à tous les membres du personnel.

Réponse de la direction

La direction est d'accord avec cette recommandation et a déjà entrepris un examen à cet effet. Dans un effort pour améliorer de façon continue la prestation et l'efficacité des programmes de formation obligatoire, la direction révise actuellement son modèle de prestation. Une recommandation concernant d'éventuels changements sera présentée à l'équipe de direction de la DSLD au deuxième trimestre de 2009.

Recommandation 74

Que la Direction élabore un manuel complet destiné aux formateurs en perfectionnement du personnel comportant des profils de formation exhaustifs pour chaque thème abordé en milieu de travail.

Réponse de la direction

La direction est d'accord avec cette recommandation, dont la mise en application est en cours. La DSLD fusionnera les programmes de formation existants, élaborera un manuel complet qui comportera tous les éléments abordés dans l'orientation générale du personnel, et l'affichera dans Ozone avant le quatrième trimestre de 2008.

Recommandation 75

Que la Direction élabore un cadre stratégique d'investissement dans le personnel qui orientera les efforts de formation propres aux foyers et alignera les ressources restreintes pour un perfectionnement efficace du personnel.

Réponse de la direction

La direction est d'accord avec cette recommandation. Le Comité d'apprentissage et d'épanouissement professionnel détermine les besoins en formation par l'entremise d'une évaluation annuelle des besoins du personnel. L'équipe d'apprentissage et d'épanouissement professionnel présente un plan de formation annuel à l'équipe de gestion de la DSLD aux fins d'approbation. La priorité pour une participation budgétisée du personnel à la formation est établie à partir des besoins énoncés dans le plan annuel.

Conclusion

La Direction des soins de longue durée et ses quatre foyers fournissent des soins et des services de qualité axés sur les résidents. De plus, les foyers ont mis en pratique la Déclaration des droits des résidents; ils observent les normes de conformité du MSSLD et suivent de façon uniforme, en grande partie, les politiques de la Direction. Bien que, à l'occasion, les foyers présentent des normes non satisfaites, les problèmes de conformité sont traités dans les plus brefs délais et de manière appropriée, à l'exception des séances annuelles de formation en milieu de travail pour la totalité du personnel et de l'accréditation des travailleurs des services alimentaires. Il existe des exemples d'innovation et d'élaboration créative de programmes au sein de la Direction et de certains foyers. Ces progrès et ces réalisations relatifs aux pratiques de soins et de services sont systématiquement transmis à tout l'organisme, qui les met en application en tant que nouvelles pratiques exemplaires. Il n'en demeure pas moins des différences marquées entre les foyers, et ce, malgré des efforts importants et permanents de normalisation.

En ce qui concerne la comptabilité de fiducie et d'hébergement réalisée par l'Unité du soutien financier, on observe d'importantes lacunes dans la gestion des dossiers. Malgré quelques plaintes, le manque de politiques et de procédures écrites, ainsi que de preuves documentaires, pose des risques à la Ville. Ces pratiques doivent être revues à la lumière des normes du programme du MSSLD et de la *Loi sur les fiducies*. Une révision des pratiques s'impose afin de s'assurer de la présence d'une documentation appropriée et complète dans les dossiers de tous les résidents. Il serait judicieux d'élaborer un nouveau sondage sur la satisfaction afin de mesurer le succès de ces initiatives.

La Direction doit revoir son cadre de gestion et de responsabilité financières. Ce secteur présente un manque inhérent de mesures de contrôle des stocks/immobilisations, ainsi qu'une supervision et une vision à long terme limitées. Il manque de mécanismes adéquats de présentation de rapports que la direction pourrait consulter pour assurer une prudence et une probité convenables à l'endroit des fonds publics. Les processus budgétaires n'ont pas adopté les pratiques modernes de la fonction de contrôleur, et leur élaboration recourt plutôt à une approche descendante qu'à une participation des différents niveaux de gestion. De plus, les budgets sont élaborés à partir de la capacité financière au lieu des besoins et ne tiennent pas compte des coûts liés au cycle de vie ou des plans d'immobilisations à long terme.

Remerciements

Nous tenons à exprimer notre reconnaissance au personnel et à la direction de la Direction des soins de longue durée; au personnel des soins et des services directs des foyers de soins de longue durée; et au personnel des Centres d'excellence, pour leur collaboration et leur assistance tout au long du processus de vérification.

1 INTRODUCTION

The Audit of the Long Term Care Branch was included in the 2008 Audit Plan of the Office of the Auditor General, first presented to Council in May 2005.

2 BACKGROUND

At the time of this audit, the Long Term Care (LTC) Branch was part of the Community and Protective Services Department (CPS) and reported to the Deputy City Manager. The Branch consisted of four long term care homes each with an Administrator reporting to the Director of Long Term Care. In late 2008, the LTC Branch was dissolved and each home administrator now reports to the General Manager, Social Services. As the audit was conducted prior to this re-organization, the report reflects the previous administrative structure. (Refer to Figure 1). The 2007 Budget for the Branch operations was $46.3 million with a net levy requirement of $8.1 million exclusive of debentures.

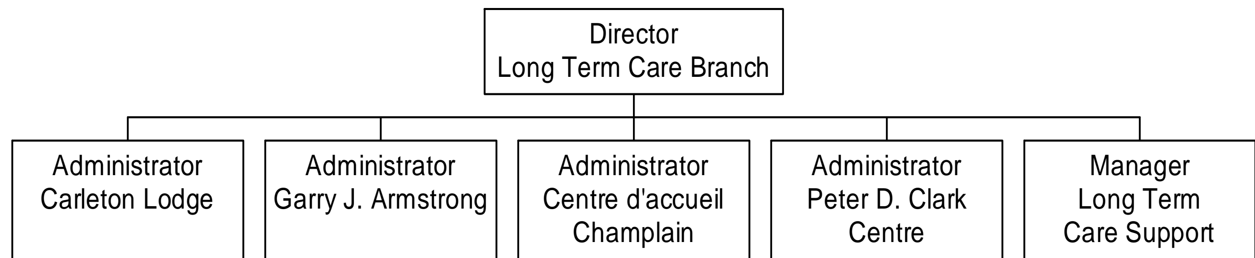

Figure 1: Long Term Care Branch Organizational Chart

The homes receive support from the administrative arm of the Branch as well as from the Centres of Excellence (COEs). The COEs consist of the Financial Support Unit (FSU), Real Property Asset Management (RPAM) and Human Resources including Health and Safety.

Until the new Long Term Care Homes Act (2007) receives Royal Ascent, the City's homes continue to operate under the *Homes for the Aged and Rest Homes Act* (the Act) and service agreements with the Ministry of Health and Long Term Care (MOHLTC).

The Act also sets out a fundamental principle that represents a key consideration for this audit; that is, that the residents residing in the City homes receive quality care and services that meets their needs. This principle, as defined in subsection 1.1(1) of the Act states:

> *"The fundamental principle to be applied in the interpretation of this Act, the regulations and a service agreement relating to a home is that a home is primarily the home of its residents and, as such, it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in*

accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."

Under the terms of the service agreement between the City homes and the Champlain Local Health Integration Network, the City agrees to operate the homes within the legislative provisions of the Act. The degree to which the homes' operations are compliant under the Act is determined through the annual compliance review program undertaken by Compliance Advisors of the MOHLTC Performance Improvement and Compliance Branch. The homes also participate in the voluntary evaluation conducted by the Canadian Council on Health Services Accreditation.

In total, the Branch operates 711 beds across its four homes, thus representing 15% of the total 4,694 long term care beds operating in the City of Ottawa. The four homes are geographically distributed across Ottawa and each exemplifies unique characteristics, services and organizational cultures (Refer to Figure 2).

Figure 2: Summary of Key Characteristics of the City of Ottawa Homes

LTC Home	Number of Beds	Location	Opening Date of New or Renovated Building	MOHLTC Structural Compliance	Unique Characteristics
Carleton Lodge (CL)	160	Nepean	1989	A	On-Site ADP
Centre d'accueil Champlain (CAC)	160	Vanier	1998	A	On-Site ADP Francophone
Garry J. Armstrong (GJA)	180	Central Ottawa	2005	A	Bilingual
Peter D. Clark Centre (PDC)	211	Centrepointe	2001	A	Bungalows
Total Municipal Beds	711				

Each of the four homes has a similar organizational structure (Refer to Figure 3). It should be noted that at Centre d'accueil Champlain, the food services are outsourced and therefore it has a slightly different organizational chart. Furthermore, all administrative staff report to the Manager of Long Term Care Support at the Branch headquarters.

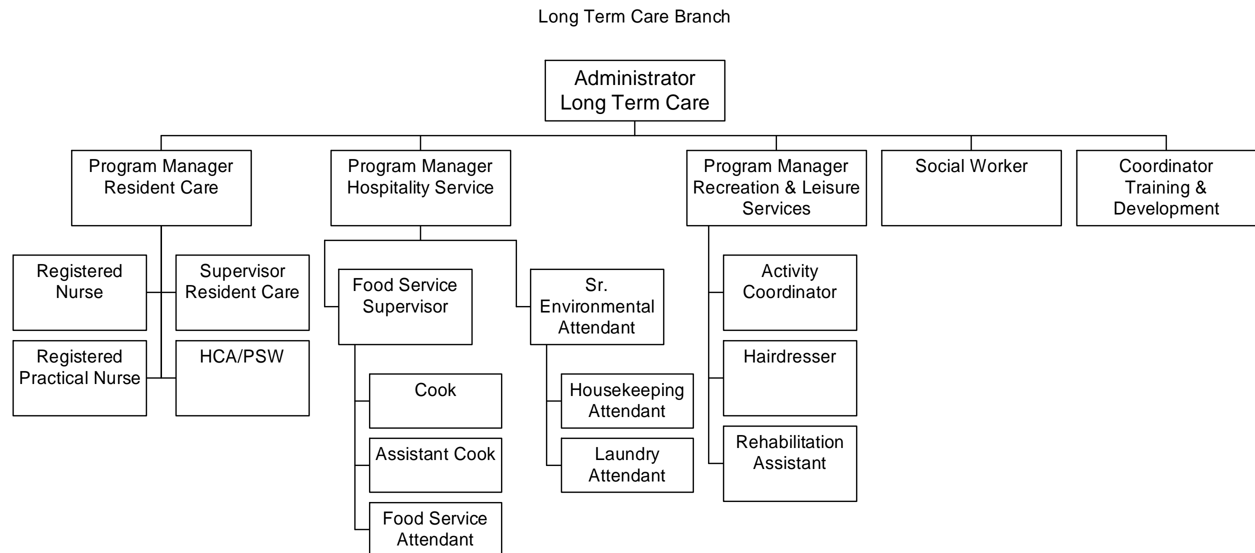

Figure 3: Long Term Care Home Organizational Chart

3 AUDIT OBJECTIVES

3.1 Audit Objectives: Compliance

1. To assess the degree to which City policies and procedures are in accordance with legislation.
2. To determine the degree of compliance with the City's policies and procedures including corporate and Branch policies.
3. To assess the LTC Branch planning and performance measurement processes and alignment with City/Department/Branch short and long term plans.

3.2 Audit Objectives: Financial Management

1. To determine if accommodation revenues have been maximized within Ministry of Health and Long Term Care Standards.
2. To assess if provincial subsidies and grants are maximized.
3. To assess the effectiveness of the internal control framework as it relates to the management of the resident trust accounts.
4. To evaluate the effectiveness of the budget process in order to meet departmental and home based goals, objectives and legislated requirements over time.
5. To assess the effectiveness of the control framework and risk management practices.

6. To analyze the financial reports for relevance, reliability and comparability between years, homes and external benchmarks.
7. To review current revenue streams and cost recovery structures to assess if revenue streams are maximized.

3.3 Audit Objectives: Performance

1. To evaluate the degree to which the homes respect the Resident Bill of Rights.
2. To evaluate the business planning process for effectiveness in setting and achieving goals and objectives.
3. To assess the effectiveness of the model of Centres of Excellence services from a long term care perspective.
4. To determine the degree to which the current Branch and home organizational structures promotes accountability.
5. To determine the effectiveness of quality management system in identifying quality initiatives and risk management.
6. To assess the degree to which the homes adopt industry best practices.
7. To evaluate resource utilization in the context of legislative requirements, efficiency and effectiveness.
8. To assess the level of service and satisfaction of residents, families and taxpayers with the four long term care homes.
9. To assess the readiness and understanding of the Branch to move to full accrual accounting as required by the Public Sector Accounting Board (PSAB) in 2009.
10. To evaluate the degree to which assets are safeguarded and managed.
11. To assess the effectiveness of the human capital and investment plan.

4 AUDIT SCOPE

This audit included the City's LTC Branch and its four long term care homes located across the City. The audit comprised all three components of an audit: compliance, financial and performance. However, the primary focus of the assignment is the performance (value-for-money) component. With respect to periods for results, this audit focussed on 2006 to 2007 but included a review of 2005 in cases where more recent information was not available due to timing.

In addition to the three audit areas described above, this report presents a summary of the analysis conducted in 2001 by the former Audit and Consulting Services regarding alternate service delivery options for Long Term Care.

5 APPROACH

The audit team utilized a combination of interviews, documentary, observation and analytical procedures in order to complete this audit. Interviews included staff within the homes, the LTC Branch and the FSU, a corporate unit with dedicated staff to long term care. Observations were undertaken in each home at varying times of the day and off hours as well as in corporate offices for administrative review. Documentation review consisted of policies, procedures, reports, audits, financial results for the City and Branch as well as other municipalities.

6 OBSERVATIONS AND RECOMMENDATIONS

6.1 COMPLIANCE

6.1.1 Compliance Audit Objective 1

To assess the degree to which City policies and procedures are in accordance with legislation. The focus will be on compliance with Long Term Care Homes Act, Ministry of Health Long Term Care program standards and the Occupational Health & Safety Act.

Audit Criteria

- Policies are adapted in accordance with changes required by the Ministry of Health and Long Term Care or other governing bodies prior to the effective date of regulatory/ standards changes.
- City processes for policy changes are designed to respond to unexpected legislative and standard changes.
- The LTC Branch is proactive in developing policies and procedures by participating in MOHLTC information sessions and keeping abreast of changes as they are revealed and/or announced.
- Policies reflect the legislative changes as intended.
- Policies are consistently communicated to all stakeholders; this includes the LTC Branch, corporate functional specialists (LTC supports) within the homes (to all levels of staff, volunteers, families and residents).
- Policies and procedures are effectively implemented and are accessible to all stakeholders, including all levels of staff, managers, and affiliates of the Centres of Excellence.
- The LTC Branch reviews and evaluates policies and procedures to assess appropriateness and relevance with respect to LTC standards.
- The Branch and home internal auditing process and plans are effective and reflect the requirements of MOHLTC and accountability framework of the Act and City.
- Compliance feedback and recommendations are addressed effectively and efficiently with an integrated approach. The approach provides a

feedback loop to various levels of the organization as well as the policy/quality management process.
- Orientation and mandatory staff training includes corporate and Branch policies and procedures.

Observations

Overall, there were appropriate policies and procedures in place consistently across the homes. Policies and procedures are comprehensive and generally understood by managers and staff. The homes have remained current with legislative changes and industry practices; policies and procedures are in most instances in accordance with legislative changes.

Compliance with Legislation and MOHLTC Program Standards

There were a number of key policies that had effective dates of April 1, 2006 set by the MOHLTC. These were tested as were other recently announced changes, including the qualification requirement changes for dietary staff.

The Branch was responsive in the development of policies to roll-out to the homes to promote compliance with MOHLTC standards and requirements. The policies were consistent with best practices. The worksheets utilized by the homes as part of the new MOHLTC changes supported Branch policies, however, they were inconsistent across the homes in some area domains (for example, the food and fluid intake record). The issue of inconsistencies between homes regarding policies and procedures is discussed later in this report.

Food Service Supervisors indicated that they believed that 50% of their Food Service Aides had their Food Service Worker Certificate. However, those in supervisory positions were not able to confirm definitively that the standard was being met. The availability of regular staffing statistics would allow managers to readily confirm that standard requirements are being met for requirements such as Food Service Worker Certification, annual renewal of registration for staff and CPR certification status.

Although the Orientation Guide is comprehensive and evaluations are complete, the Staff Training Policy does not fully meet the mandatory training requirements as defined by the MOHLTC Standards. The MOHLTC identifies annual training requirements that must be conducted by all LTC homes on an annual basis. Currently, the homes are not meeting requirements as they identify only four of the mandatory ten areas. Further, the homes are targeting 70% staff participation versus the 100% required for full compliance.

Currently, compliance plans are not forwarded for central review vis-à-vis consistency in approaches and commitments prior to submission to the MOHLTC. This is atypical in an organization with multiple LTC sites. A central review ensures that there is consistency in commitments across the Branch. Although there

have been some unmet standards, the homes have been responsive such that the most recent compliance reviews have been favourable.

Recommendation 1

That staffing statistics be available to managers at the homes so that they are readily able to confirm that standard requirements are being met (for example Food Service Worker Certification, annual renewal of registration for staff and CPR certification status etc.).

Management Response

Management agrees with this recommendation and it is current practice. Staffing statistics are currently available to managers via a request to administration to print a report from the LTC staff training and development database, as well as in the employee's personnel file. Information in the staff training and development database is scheduled for conversion to SAP in Q1 2009 and will continue to be accessible to administration staff, but will be available to managers at their desktops.

Recommendation 2

That the Branch review the MOHLTC standard for mandatory training, measure adherence and revise accordingly with the goal of meeting the expectation that 100% of staff are attending all annual mandatory training as defined by MOHLTC standards.

Management Response

Management agrees with this recommendation. However, it is important to note that there is a difference between mandatory training requirements of the Ministry of Health and Long Term Care and developmental training provided by the LTC branch.

In an effort to improve delivery and effectiveness of mandatory training programs, management has reviewed a training delivery model that would ensure 100% completion of training by all full-time, part-time and casual staff members. The estimated costs of this model are $195,000 for staff attendance and $90,000 for implementation. Funding for this model will be brought forward as an identified pressure in the LTC 2010 budget.

Recommendation 3

That the Branch develop a process by which the compliance plans are vetted centrally prior to submission for consistency and are accessible by the other homes to allow all homes to be more proactive in ensuring that their home meets or exceeds compliance standards.

Management Response

Management agrees with this recommendation. The director of LTC currently reviews all compliance plans before submission to the MOHLTC. In addition, annual compliance plans are reviewed by the Branch management team (which includes representation from all four of the City's homes) to identify policy, procedure and best practice implementation. The process will be documented to clarify for managers who may be non-compliant. The compliance plans are available centrally in the Branch office. Electronic availability will be reviewed in Q2 2009.

Policy and Procedure Manual Format

The Branch has a large number of policies and procedures and there is a regular cycle for updates and new policies introduced to meet legislative requirements. Policies are easy to read and their format is consistent for the reader to follow. However, the policy manual is arranged in such a way that it would be difficult to find policies for specific items. For example, resident trust and accommodation policies are found in both the Administration and Home Administration sections. There is inconsistency for Human Resources (HR) policies. HR policies appear in many places. There also seems to be duplication of policies between areas and the numbering is inconsistent.

The policy manual and distribution list denotes the location in which the policy manuals are to be kept. During the audit process in the homes, it was observed that policy manuals were not always readily accessible and were not located in close proximity to the staff workstations for ease of reference and access to pertinent information. At Carleton Lodge and Peter D. Clark Centre, infection control manuals and food service manuals were not readily accessible for staff. The risks include non-adherence to policies or ill informed actions in potentially serious situations such as an emergency, if policies cannot be readily accessible to staff.

Recommendation 4

That during the next round of policy reviews, a restructuring take place so it is easier for various levels of staff to find appropriate policies (for example, having discrete sections for resident information, trust accounting, human resources, etc.).

Management Response

Management agrees with this recommendation. LTC policies are currently divided into the following categories: food services, laundry, housekeeping, resident care, recreation and leisure, social work, medical, infection prevention and control, health and safety, emergency response and administration (home/office and branch).

Policies regarding trust accounting are maintained by the FSU. Human resources policies are corporate. All LTC and corporate policies are accessible to staff through Ozone. Also, all LTC policies are provided in print manuals located in designated areas at each home and in the Branch office, which has been communicated at both general staff meetings and management meetings. The location of LTC-specific policies by service area will be reviewed as part of the three-year comprehensive cycle. The next cycle will begin in summer 2009. As part of this process, staff will review the policy and procedures manuals and associated indices from other LTC organizations of comparable size and structure.

Recommendation 5

That the Branch determine key locations for storage of policy manuals to ensure that staff have ready access to necessary information and a means to verify that they remain current.

Management Response

Management agrees with this recommendation. The branch office currently designates and maintains a list of the locations for policy and procedure manuals as indicated in the policy and procedure (reference no. 700:02 Policy and Procedure Manual) approved in November 2005 and revised in March 2006. The administrative assistants in each Home are responsible for replacing revised and new policies and procedures in each manual. In addition, all LTC branch policies and procedures have been accessible through Ozone since 2007. The location, both physical and electronic, of LTC-specific policies by service area will be reviewed as part of the three-year comprehensive cycle. The next cycle will begin in summer 2009.

Policy and Procedure Development and Review Practices

Branch-wide policies are centrally created and rolled out to the homes for implementation. Staff, where time permits, have an opportunity to provide input for policy development and feedback on draft policies. Policies have been developed consistent with best practices in the long term care sector. Branch-driven policies are utilized consistently across the homes and the approved policy development flow-chart is being followed for such policies.

Home-specific policy development is not consistent across the homes. Procedures in support of policies are also inconsistent between homes. For example, the food and fluid intake record. The intake record at Carleton Lodge is conducive to the collection of data to meet MOHLTC requirements for documentation and evaluation of the 1.5 L fluid requirement. Conversely, the current intake record at Peter D. Clark Centre does not as readily allow the care staff to accurately record the volume of fluid intake. The record is not completed close to the time of the consumption or consistently for the residents at Peter D. Clark Centre; hence,

reducing the accuracy of the record keeping. Hence, the ability to measure the intake record accurately or the ability to calculate intake volumes such that it can be illustrated to meet legislative requirements (i.e., 1.5 L of fluid) is inconsistent across homes.

There is a Branch policy that identifies the process for authorization (i.e., through the Administrator) for in-home policies but application of such policy is inconsistent across the homes. The Branch is encouraged to review its practices on home-specific policies and determine which policies and/or worksheets need to be home-specific and which are best to be Branch-driven to promote consistency. This will ensure that where the home requires home-specific policies they are approved consistent with the Branch's policy and that consistent forms are used to support policies. Centralization of policies reduces the risks for variability, deviation from approved best practices and promotes opportunity for verification by the Branch manager and a common platform for discussions amongst managerial meetings.

There is a three-year policy review cycle but it is not systematically based on priorities and evolving changes during the cycle. For example, there has been a recent change in reporting to MOHLTC, what was formerly referred to as "unusual occurrences" and is now called "critical instances". At the time of the audit, the policy had not been updated to reflect the change in terminology and/or submission methodology. The policy review cycle should include a work plan highlighting the policies to be reviewed and target dates based on priorities and legislative or regulatory changes.

With respect to Occupational Health and Safety, the Branch relies heavily on Employee Health and Wellness for advice. Although there is an initiative to update policies to address health and safety, the policies here are not in line with the Health Care Regulations (as the Ministry of Labour would expect to see). The Branch is undertaking a policy review with the view to identify areas where health and safety requirements are lacking.

Recommendation 6

That the Branch review its practices on home-specific policies to determine which policies and/or worksheets need to be home-specific and which are best to be Branch-driven to promote consistency.

Management Response

Management agrees with this recommendation. LTC has a policy and procedure regarding the development process for new policies and procedures (reference no. 700:02 Policy and Procedure Manual). All policies and procedures have a designated group for approval and any home-specific policies must be brought to the approving body for review and approval.

This level of consistency review may not have been clearly articulated in the policy and procedure document therefore, it has been modified to reflect a requirement for referral of home-specific policies and procedures to the branch management team for review and approval.

Recommendation 7

That the Branch's three year cycle for policy review include a work plan highlighting the policies to be reviewed and target dates.

Management Response

Management agrees with this recommendation. Work plans highlighting policy review target dates are coordinated by each functional team area, which maintains approval authority for the policies and procedures. LTC will review the centralization of these work plans in Q1 2009 and will include this requirement in the functional team terms of reference. In addition, a requirement to report on progress will be incorporated into quarterly LTC reporting requirements. As a result of this review, the branch may need to request funding in the next budget for a centralized FTE to fulfill this role.

Recommendation 8

That the Branch review its Health and Safety policies to align them with the Health Care Regulations in order to assist the Branch to respond more succinctly to a Ministry of Labour Inspection and ensure that it meets operating requirements.

Management Response

Management agrees with this recommendation. The Occupational Health and Safety division will assist LTC with a review of their health and safety policies by the end of Q2 2009, in an effort to better align them with Health Care Regulations.

Policy Implementation and Communication Practices

Interviews with key managers indicate that there is a general understanding of policies and that they are made aware of changes quickly and effectively through management team meetings and communications. Interviews with staff indicated that they are verbally advised of changes in policy and that there had been a recent practice introduced or forthcoming whereby the policy would be attached to their pay stub.

Committee meetings minutes were reviewed to determine communication patterns for change in policy or where feedback on draft policies had been elicited by the homes. The availability of minutes in homes was not consistent. Champlain and Garry J. Armstrong had organized, complete and easily accessible minutes for all committees. Carleton Lodge had incomplete minutes for a number of committees

and for the remaining committees, there was difficulty in accessing the minutes. However, significant improvement was noted in this home over recent months as stability is being re-established by the new leadership team.

The minutes did not have a consistent format within the home or between homes. Further, the minutes were not action driven such that accountabilities and target dates for completion and follow up are clearly articulated. The business arising sections were sporadic and incomplete. There were a number of items that were identified but not carried forward to the following meeting minutes/agenda. It was unclear if resolutions had been reached. In some cases, items were deferred over numerous meetings or had been dropped without action.

For each committee, the terms of reference should specify the standing agenda items to be addressed at each meeting. A master schedule with the various committees should be planned on an annual basis and distributed for leadership reference.

The newsletter at Champlain "Journal interne Soins infirmiers" outlining indicator information, areas of success and upcoming quality improvement initiatives is an excellent source of communication and reflects best practices. The departmental newsletter helps the home review practices and serves as an excellent vehicle to deliver messages to front-line staff on policy change or the impact of such change.

Recommendation 9

That methods of communicating policy change be measured for effectiveness and that access to online policies for care staff be explored as an option to increase accessibility.

Management Response

Management agrees with this recommendation. Access to online policies and procedures has been in place since 2007. Effectiveness of the communication of policy changes is measured as part of the annual compliance review by the Ministry of Health and Long Term Care and in the LTC accreditation process that takes place every three years. An internal measurement tool will be reviewed and considered in Q3 2009.

Recommendation 10

That policy changes be discussed and minuted at appropriate committees on a consistent basis.

Management Response

Management agrees with this recommendation and it is current policy. As part of branch policy and procedure (reference no. 700:02 Policy and Procedure Manual) it is the responsibility of functional teams to consistently review and record policy changes. The terms of reference for functional teams was reviewed in Q1

2009 and the specific responsibility for policy and procedure review will be documented to improve consistency in practice.

Recommendation 11

That the Branch develop a consistent policy regarding meeting protocols and records retention practices, including a standard meeting agenda format, a minute template to be used for all meetings and a master schedule with the various committees planned on an annual basis and distributed for reference.

Management Response

Management agrees with this recommendation. To meet accreditation requirements there are terms of reference in place for all committees of the LTC branch. The last review was completed in 2007. LTC will review the use of master templates across the branch versus across homes in Q1 2009. LTC will consider the expansion of master home schedules to a master branch schedule. As a result of this review, the branch may need to request funding in the next budget for an FTE to fulfill this function.

Recommendation 12

That the Branch adopt the practice that has been employed at Champlain for the "Journal interne Soins infirmiers".

Management Response

Management disagrees with this recommendation. There are branch and home templates for staff, resident and family newsletters. The practice at Champlain represents a diversion from branch policy and a duplication of work. This practice represents an inconsistency in staff communication and the branch director would like to see it discontinued by Q4 2008. Elements of the Champlain newsletter will be incorporated into the templates. The required process will be documented as part of a long term care comprehensive communication program for staff.

6.1.2 Compliance Audit Objective 2

To determine the degree of compliance with the City's policies and procedures including corporate and Branch policies.

Audit Criteria

- Policy documents are easily accessible, up to date and functional specialist contacts are known.
- Policies are supplemented with current procedures in order to facilitate understanding by all staff and implementation consistency across all homes.

- Policies and procedures are appropriate to the long term care business and are complete and comprehensive.

Observations

Compliance with Corporate Purchasing Policy

The corporate Purchasing Policy is clear and many standing offers have been established with various vendors. Most purchasing in the Branch is undertaken based upon standard offers. However, due to the nature of the long term care business, the Purchasing Policy is not always appropriate. This is particularly evident in food services. Although most food services products are purchased based upon standing offers, timing and types of food requirement has led to the use of other vendors.

The stores person performs a significant amount of the purchasing activity, particularly for medical supplies. The stores person performs a physical count and orders based upon levels of inventory remaining. The stores person's duties include ordering, receiving and stocking of stores. The lack of segregation of purchasing functions and controls creates the risk of loss.

Purchasing is a manual process whereby telephone orders are placed and recorded by the stores person on a memo pad. One day per week, the stores person receives the goods purchased and places them in inventory. All of this is done on paper and there is no reconciliation of inventory to expenses.

It was also noted that managers contact the stores person to purchase items from local businesses without competitive quotes. The reason for the purchases was unclear in some cases. This practice is in violation of the corporate Purchasing Policy and there is a risk of procurement being undertaken that was not authorized.

Procurement cards are primarily used by managers and the stores person for small items or urgent requirements. It should be noted that although the electronic system is being utilized to reconcile the charges against the statements, there were many instances where receiving activities were not documented.

Further, staff cardholders allow others to charge items to their cards. The corporate Purchasing Policy states that written authorization is required to allow for other charges. The authorization is to be retained in the cardholder's file. Management indicated that it is Branch policy not to allow cardholders to have others charge to their cards and therefore, no authorizations were obtained. However, staff indicated that in fact, they allow others to charge items to their cards. For example, the stores person performs purchasing functions for all four homes. It has been a practice to contact the stores person to pick up various items while on the road to homes. Further, the stores person orders supplies on behalf of homes such as medical supplies. In order to facilitate this, vendors have purchasing card numbers on file for use when calling in orders. These are, however, generally with vendors

that have standing orders. Documentary evidence of card statements confirmed this. These charges must be approved by the cardholder and included in their reconciliation.

In most cases of procurement card usage, the majority of transactions were not signed nor was there indication that the goods were received. In many cases, no signature or explanation was attached to the invoice.

Recommendation 13

That the Branch **review its purchasing practices to ensure that appropriate segregation of duties, documentation and settlement processes are implemented.**

Management Response

Management agrees with this recommendation. LTC and Financial Services have conducted a review of the branch's purchasing practices and have implemented appropriate segregation of duties or mitigating controls.

Recommendation 14

That the Branch review its use of procurement cards and approval processes to ensure compliance with the corporate Purchasing Policy, including requiring any cardholders who allow others to make charges to their card to provide the appropriate written authorization.

Management Response

Management agrees with this recommendation. As stated in the corporate purchasing card policy and procedures, cardholders shall not share their cards with other individuals unless their director has given written approval, in order to meet operational needs of the department. LTC is now in compliance with this procedure as the management team have provided written authorization to the store person to place orders on their behalf. In order to minimize any additional future risks, the branch has implemented an internal policy whereby all orders placed by the store person will be processed against their purchasing card. The purchasing card is then reconciled and approved on a monthly basis by the store person's manager and Financial Services as outlined in the purchasing card procedures.

The Auditor General also noted in the audit report that items were purchased without competitive quotes. Competitive quotes were not required as the purchases were of an urgent nature and were of a small dollar value.

LTC implemented a cooperative purchasing process in 2007 through a consolidation of the request for tender process across the homes. Purchasing for medical supplies, food and environmental services is coordinated through standing offers.

Gaps in Existing Policies

As was discussed earlier, there are some gaps in policies. In particular, there are some MOHLTC requirements, such as mandatory training that are not complete and represents exposure/risk to the City. Specifically, the MOHLTC mandatory education requirements include the expectation that 100% of all staff will complete the 10 key mandatory training on an annual basis. The Branch policy for education targets is 70% attendance.

The FSU performs the majority of the financial transactions with respect to the homes. Consequently, there are few Branch specific policies related to the financial management of the homes and Division. The lack of policies with respect to accounts receivable puts the City at risk with respect to collections and cash flow.

Further, with respect to admissions, trust and accommodations, there are few written policies in this area and existing policies are very vague and leaves much discretion in the interpretation. The current policy indicates the documents that must go to the FSU upon admission but there are no policies around the appropriate treatment of the trust at the homes or the FSU on an ongoing basis. No policy exists for the items that should form the resident files nor is there an annual review process to ensure the admission agreement is up to date. There is also no written policy regarding items being charged to the trust that were not included in the admission agreement. The FSU has started to document procedures, however, current policies do not ensure that the MOHLTC program standards are met. There is little guidance for those in the homes and there is no annual admission agreement process to update information. More detailed observations related to financial management are discussed under the Financial Management audit objectives in this report.

Upon orientation, managers are provided training and the Manager's Tool Kit is provided to all new managers. However, the Manager's Tool Kit is still under development and requires several sections to be completed. New and existing managers indicated that these documents were useful as were the contacts with the LTC Branch and the FSU. Although the Toolkit mentions the Ozone intranet site, managers often refer to the Toolkit after orientation.

Recommendation 15

That the City complete the procedures in the Managers Tool Kit and combine the various manuals into one key binder as well as update the Ozone intranet site.

Management Response

Management disagrees with this recommendation. The 'LTC Managers Tool Kit' was developed as an orientation tool for new managers in LTC. The toolkit is a reference manual, not a policy and procedure manual and refers managers to Ozone for various types of information. The toolkit is updated regularly, as new information becomes available via e-mails to managers. It is the individual

responsibility of each manager to insert the revised information into their respective manual. This process will be reviewed and the reassignment of this task to the same responsibility centre for revisions to other policy and procedures manuals in each home will be considered. The toolkit has been shared at a departmental level. It is outside the scope of authority for the LTC branch to make this toolkit a corporate resource.

6.1.3 Compliance Audit Objective 3

To assess the LTC Branch planning and performance measurement processes and alignment with City/Department/Branch short and long term plans.

Audit Criteria

- The Branch and Department plans and goals are aligned with the City's strategic directions.
- The Branch meets the cost containment and gapping requirements as outlined in the City's budget.

Observations

The primary focus of this objective was to review the LTC Branch planning processes as they compare and contrast to well-established standard practices within the industry. The Branch and its four homes are very committed to ongoing planning across the varied operational domains. This commitment was expressed by staff of different classifications and Units within each of the homes.

Planning Initiatives

The 2006, 2007 and 2008 work plans of the Branch and each of the homes were reviewed. While there is no clear link to the City's strategic plan and the CPS Plan provided limited Branch-specific direction, the Branch plan is comprehensive and congruent with its mission, vision and values. Of note is the fact that the CPS Departmental plan is up for review in 2008.

The Branch plan sets out the four pillars of excellence, including excellence; home-like environment; learning and growth; and, planning and communications. Within these pillars, the plan presents key Branch-wide initiatives to be addressed within the planning year horizon. As such, its direction for the upcoming year is associated with a myriad of project-specific plans.

Within the homes, staff were knowledgeable of the four pillars and the general importance of it in directing the organization into the future. There are inconsistencies between the homes with respect to format, comprehensiveness and performance measures. The 2008 work plans of Garry J. Armstrong and Champlain represent solid examples of good planning documents and thus, establish a framework and benchmark to be used by all homes within the Branch to improve work planning.

Alignment with Key City Plans

While LTC was not a key focus of the 2005-2007 CPS Strategic Plan, there was an expectation that the Branch would undertake competitive service delivery reviews. The CPS Plan also stated that the Branch would develop and implement a comprehensive volunteer plan and there is evidence of some recent best practices implementation specific to volunteer participation in the homes. The Branch successfully completed a group accreditation with the Canadian Council on Health Services Accreditation (CCHSA), thereby fulfilling the third expectation in the CPS plan.

The CPS departmental emphasis on continuous service improvement has been wholeheartedly adopted by the Branch and the homes. Continuous improvement is incorporated into all the planning activities and is supported by a performance management framework. The Branch enjoys the benefit of a dedicated position to manage the performance indicator and balanced scorecard activities.

The Balanced Scorecard framework is used by the Branch for the planning and development of its annual work plan which is in turn used by the homes as a guide for their own internal annual work plans. The Branch has developed a set of indicators for each pillar which are used by the Branch and managers in the homes for planning and continuous quality improvement initiatives. The goal of each pillar is shown in the table below as well as some sample metrics.

Excellence	Home-Like Environment	Learning and Growth	Planning and Communications
To position the City of Ottawa's LTC homes to achieve excellence through the use of evidence based best practices to meet-exceed legislative standards.	LTC homes will be maintained in a home-like, safe, secure manner to support high quality client focused care, minimize risk, and maximize occupancy levels.	To build a strong workforce by investing in our staff, developing a long term retention strategy, and developing programs that support continuous learning.	To position the City's LTC homes as the homes and employers of choice in Ottawa long term care and the health care sector.
LTC Cost (CMI adj) per Weighted Resident Day	Medication Errors	Staff Education Average Cost	Annual Occupancy Rate
Energy Consumption Rate	Mandatory Monthly Fire Drills	Sick Pay Expense	Ratio of Municipal Beds to Total Beds
OT hours as percentage of Budget	Accreditation Award	Sick Day Expense as percentage of Budget	Percentage of Community Needs Satisfied

While the transition to full performance management practice is ongoing, there is some evidence that managers across the Branch use the Balanced Scorecard reports both in their functional teams and individual departmental planning tasks.

Additional observations related to performance measurement appear in the Performance audit objectives of this report.

The CPS plan referenced the Staff Investment Strategy. The work plans of each home reference the staff investment initiative (and/or team). The homes actively engage staff in a variety of activities to understand their workplace issues and concerns including satisfaction surveys, town hall meetings, and training needs surveys. However, as will be noted later in the document, the $30,000 training budget for staff training is grossly inadequate to enable the part-time education coordinators and managers within the homes to deliver training to staff in the changing LTC environment.

Recommendation 16

That a standardized work planning process be established across the Branch in order to roll up to the Branch-wide short and long term planning framework and that this process be developed in line with the City and CPS Department planning frameworks and include both a reporting as well as a communication strategy.

Management Response

Management agrees with this recommendation and this is current policy. LTC has used a balanced scorecard approach to work planning since 2005. Every year LTC reviews corporate and departmental directions and priorities and incorporates these into branch-level planning. As an example, in 2008 LTC revised the balanced scorecard to reflect the City's direction toward service excellence and the departmental direction of customer service.

The LTC strategic planning and work plan development process, coupled with revision of performance measures is conducted as a collective every fall. This step is followed by the development of home-based work plans that reflect the major priorities of the LTC branch. LTC has a quarterly reporting process for the status of achievement on the branch work plan. This information is communicated at quarterly branch meetings and monthly general staff meetings. It is also communicated as an on-going component of the LTC accreditation process. The specific templates to be used will be added as supporting documentation to policy and procedure 700:34: Quality Management to increase consistency in the work plan templates.

Cost Containment and Gapping Requirements

Branch and home management are very aware of the gapping provisions required by the City and strive to meet these through non-replacement of staff for call-ins. Management understands the impact of the gapping requirement and works to minimize impact on residents. City wide expenditure constraints are in place, however, it is not clear how the reductions are calculated.

As was discussed in the 2007 Audit of 2006 and 2007 Compensation Budgets, the overall gapping provision is an arbitrary number, which leaves room for manipulation. There is no evidence that this reflects expected vacancies and timing delays encountered during the hiring process. A budget policy should be developed where a provision for staff vacancies is created in place of gapping. The provision for staff vacancies should be appropriately supported by analysis of approved and vacant FTEs with a calculation of vacancy rates. This provision for vacancies should not be used as a budget pressure or solution but should be identified at the beginning of the budgeting process when the budget is first set prior to any budget adjustments.

In response to the 2007 audit, management indicated it will develop a policy by Q4 2008 that will define the corporate direction on the use of gapping for budgeting purposes. The policy will be based on analysis of vacancies and brought to Executive Management Committee for approval.

Recommendation 17

That the Branch and FSU develop a consistent mechanism to analyze the gapping requirement against the Service Delivery Model and quality indicators such that the impact of the practice on residents can be assessed.

Management Response

Management agrees with this recommendation. A new corporate Vacancy Allowance policy has been approved by Executive Management Committee, which established a gapping rate of 1.6% per department. LTC, Financial Services and Human Resources will enhance current gapping reports to improve gap analysis so that quality indicators such as impact of the policy on service delivery can be assessed. This will be implemented by Q4 2009.

6.2 FINANCIAL MANAGEMENT

6.2.1 Financial Audit Objective 1

To determine if accommodation revenues have been maximized within Ministry of Health and Long Term Care standards.

Audit Criteria

- The preferred accommodation rates are charged to a maximum of 60% of the beds.
- Intra-facility moves between bed types are managed efficiently.
- Rate changes for moves, bed holds, changes in income and subsidies are completed in the correct time period.

Observations

Long term care accommodation revenues are comprised of basic and preferred revenues. Envelope funding from the Province is reduced by basic accommodation revenues and all preferred accommodation revenue is retained by the facility. Consequently, it is important that the home maximize preferred accommodations in order to maximize its revenues. All bed rates are regulated by the Province. Preferred rates apply to semi-private and private rooms only and are set at $8 and $18 per month respectively. These rate differentials have been in place since at least 1992 (as per O.Reg 342/96). MOHLTC program standards specifies that homes must provide for 40% of its accommodation at the basic rate. Therefore, even if the home has more than 60% preferred beds, it must charge basic rates on some of those beds.

Program Standard 0607-11 states that:

> *"the maximum number of beds to which preferred accommodation charges may be applied is calculated on individual facilities. Every facility in the province must retain a minimum of 40% of beds at basic accommodation. Facilities are not required to charge the preferred accommodation maximum. However, to ensure consistency and equality across the Province all facilities are encouraged to adopt a common preferred accommodation policy. Each facility must advise the Placement Coordination Services of the facility's preferred accommodation policy and maintain ongoing communication to clearly delineate the type and applicable conditions associated with existing vacancies."*

Preferred Accommodation Revenue

The City meets its requirements to provide at least 40% of its beds at the basic rate and in fact the Branch exceeds the requirements for basic accommodation. Garry J. Armstrong is currently the only home that is not maximizing its preferred revenues. If the City maximized preferred revenues, it would earn an additional $127,000 annually. These metrics are included in the Balanced Scorecard and are reviewed by administrators on a regular basis.

The Branch has a policy, *500.19 - When a Bed Becomes Available Policy*, which states that the Community Care Access Centre[1] (CCAC) will contact the resident or legally authorized substitute. They then have 24 hours to make a decision. If they decide not to accept the bed, the CCAC goes to the next name on the list. The CCAC then contacts the home's social worker and informs them who will be admitted and when. The applicant/legally authorized substitute then contacts the social worker to work out the admission details.

The City also has a "Change in Accommodation policy which states:

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[1] A separate external agency that is responsible for managing the LTC waiting list.

"1. The Social Worker maintains a list of residents that have been identified as requiring a transfer from one accommodation type to another (i.e., private to basic, basic to private).

2. When the Social Worker is informed that a resident/family is requesting an accommodation change, the resident's name is put on a transfer list prior to any external bed offer.

3. When a bed opening occurs, the Social Worker reviews the list and initiates any internal transfers prior to notifying the CCAC of the room and bed number.

4. The Social Worker notifies the Financial Services representative of the change in accommodation type."

Recommendation 18

That the Branch and FSU develop a preferred accommodation policy and associated procedures to be shared with the Community Care Access Centre in order to provide clarity and an avenue for communication to continue to improve preferred revenue income.

Management Response

Management disagrees with this recommendation. LTC currently has policies and procedures in place to notify the Community Care Access Centre when bed vacancies arise. This policy has been shared with the CCAC to ensure that preferred accommodation is maximized. It requires that the type of accommodation available (preferred or basic) be identified at the time of notification.

LTC complies with regulation 39.0.1 under the Homes for the Aged and Rest Homes Act which states that, "a home shall ensure that no more than 60 per cent of the bed capacity of the home is set aside as preferred accommodation". Collectively, preferred accommodation revenue was at 96% for 2006, 97% for 2007 and is at 99% as of the end of August 2008.

Intra-facility Moves

MOHLTC program standard with respect to admissions states:

"*When ward accommodation beds become available they must be filled on an alternating basis with persons who are transferring from a preferred accommodation bed within the facility and persons on facility or Placement Coordination Service (PCS) waiting lists. For facilities that currently work with a PCS, when a bed is filled from within the facility, the admission to the resulting vacant preferred accommodation bed will done by the PCS. The next vacant ward bed would also be filled by the PCS from the PCS waiting list.*"

It is important to note that the Branch policy with respect to changes in accommodation is contrary to the program standard as described above. In particular, the program standard indicates that the ward accommodation must be filled on an alternating basis between new admissions and intra-facility transfers. However, the Branch's policy indicates that intra-facility transfers are to be done prior to notifying the CCAC.

The efficiency of homes in managing moves within the facility as well as admissions is key for homes to maximize their preferred revenues. Generally, the home, through its social worker, manages its admissions and moves in an efficient manner and has ensured that vacancies are minimized. This is evidenced by the fact that occupancy rates have traditionally been over 98%. Staff are clear with respect to the requirement to maximize revenues, ensure that beds are filled in a timely manner and move residents from preferred accommodation to basic upon availability. However, this is a manual process in that the social worker tracks the beds that are being charged rates below the preferred rates in preferred beds.

This manual process represents a risk of loss when social workers are not replaced during extended absences. At one home, the social worker was away for an extended period of time without replacement. In the past, social workers from other homes would provide coverage during absences but due to workload that was not possible in this case.

As mentioned above, GJA has not maximized its preferred revenues. Management has raised its concerns regarding the admission process with the CCACs and preferred revenues have been rising steadily over the last two years. As with all homes, the management of moves and rates charged is a manual process.

Rate Changes

The City, through the FSU, bills its accommodation charges in advance and makes changes to rates after they occur. As per the MOHLTC program standards, rates to be charged on a daily basis are set out in the regulations. With respect to accommodation charges, in the month of admission and discharge, the rates are charged daily which does not include the date of admission but does include the day of discharge. Consequently, based upon the current structure and billing processes, it is imperative that information regarding admissions, moves and bed holds are communicated to the FSU on a timely basis.

The communication between the homes and the FSU is currently done via census forms that are transmitted daily. These completed forms indicate to the FSU the changes in the resident population including details regarding transfers to hospital, moves within the facility, deaths and discharges. These dates are imperative as they determine the charges for the period.

With respect to changes in rates, including bed holds, the FSU processes these in a timely fashion. The FSU charges accommodation on the first of the month for the

month following and performs monthly reconciliations to ensure rates are properly reflected for the next billing period. Documentation of rate changes, however, was not always complete in the resident files. Although procedures for informing of bed holds and moves are known and are timely, there are no detailed procedures published by the FSU and/or the LTC Branch.

It is important to note, however, that due to the manual nature of the tracking of census changes and billings, that communications between the FSU and the homes is imperative. Without properly documented procedures there is a risk of loss of revenues and/or inappropriate charges. The implementation of the Goldcare system may provide an opportunity to develop new reports to provide electronic census reports. This could include flags to assist the social workers with bed moves to maximize preferred accommodation revenues and enhance communications with the FSU regarding rate changes.

Recommendation 19

That, as part of the implementation of Goldcare, the Branch and FSU develop new reports or views from Goldcare to provide electronic census reports including flags to assist the social workers with bed moves to maximize preferred accommodation revenues.

Management Response

Management agrees with this recommendation. New reports have been developed and implemented to assist social workers to ensure that preferred accommodation revenue, which is currently maximized, will continue to be so into the future.

6.2.2 Financial Audit Objective 2

To assess if provincial subsidies and grants are maximized.

Audit Criteria

- Occupancy rate is at or above 97%.
- Envelope funding is maximized in each home and the expenses charged to the envelopes follows MOHLTC guidelines.
- Case Mix Measure (CMM) reflects acuity of the residents.
- Determine the effect that the Community Care Access Centre practices for admissions has on Case Mix Index.
- Goldcare implementation project plan encompasses all key modules of care levels with a long term vision.
- High intensity needs and laboratory fees submissions to Ministry of Health reflect full costs.
- Provincial capital grants and funding initiatives are pursued and submitted.

- Overhead and allocated administration costs from non-home specific costs reflect the true costs of corporate services.

Observations

Occupancy Target

According to MOHLTC funding requirements, subsidies are reduced by basic accommodation revenues. However, the home must also meet 97% occupancy in order to continue to receive full envelope funding. If the home experiences an outbreak leading to the cessation of admissions for a period of time and potential impact on occupancy and subsidies, the MOHLTC will take this into account and subsidies would not be reduced. Therefore, it is important that the homes and the FSU ensure that this information is submitted to MOHLTC.

The Branch monitors the occupancy rates as part of its balanced scorecard report. The waiting list in Ottawa for the City of Ottawa homes is significant (over 1,000 on the waiting list for 711 beds). Consequently the City does not have occupancy issues and does not face a risk in the future.

This is evidenced by the fact that all four homes have met or exceeded the occupancy target through a combination of need and efficient admission processes. In the 2006-07 timeframe, the lowest occupancy rate across all homes was 97.62% but generally over 99%. It is important to note, however, the staff were unclear who was responsible for reporting outbreaks and potential impact on occupancy to the finance unit of the MOHLTC. Although the homes report the outbreaks to the MOHLTC compliance unit, it was unclear if the finance group were made aware in order to ensure subsidies were not affected.

Envelope Funding

City of Ottawa homes are maximizing their funding and in fact are supplemented by taxation levies of over $8 million. This is not unusual in municipal homes due to the fact that compensation costs in municipal homes are generally greater than in the private and charitable homes.

With respect to expenses being charged to the appropriate envelope, it was difficult to ascertain this based upon the financial reports provided. There was limited knowledge of the program standards regarding appropriate expenditures that can be included for subsidy purposes. However, the City's external auditors have performed audits on the Annual Facility Reports submitted to the MOHLTC and provided a clean audit opinion in 2005 and 2006. A review of the chart of accounts of the LTC Branch indicates that it is structured in such a way to ensure it meets the reporting requirements. However, the move to full accrual accounting by 2009 will likely require changes to the chart of accounts particularly for capital. Interviews indicated that there has been no discussion within the Branch or the FSU regarding this issue and the potential impact on MOHLTC reporting requirements.

Recommendation 20

That the Branch and the FSU confirm its knowledge of the eligible expenses in each envelope on a regular basis and analyze these costs on a vertical and horizontal basis (between homes, between years and externally to other homes).

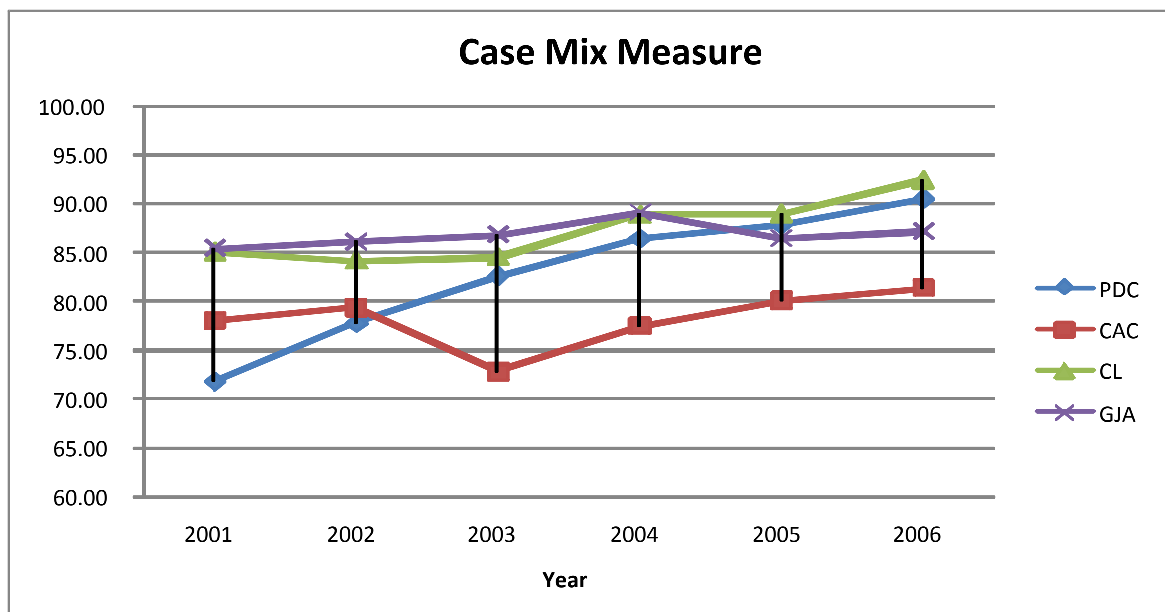
Management Response

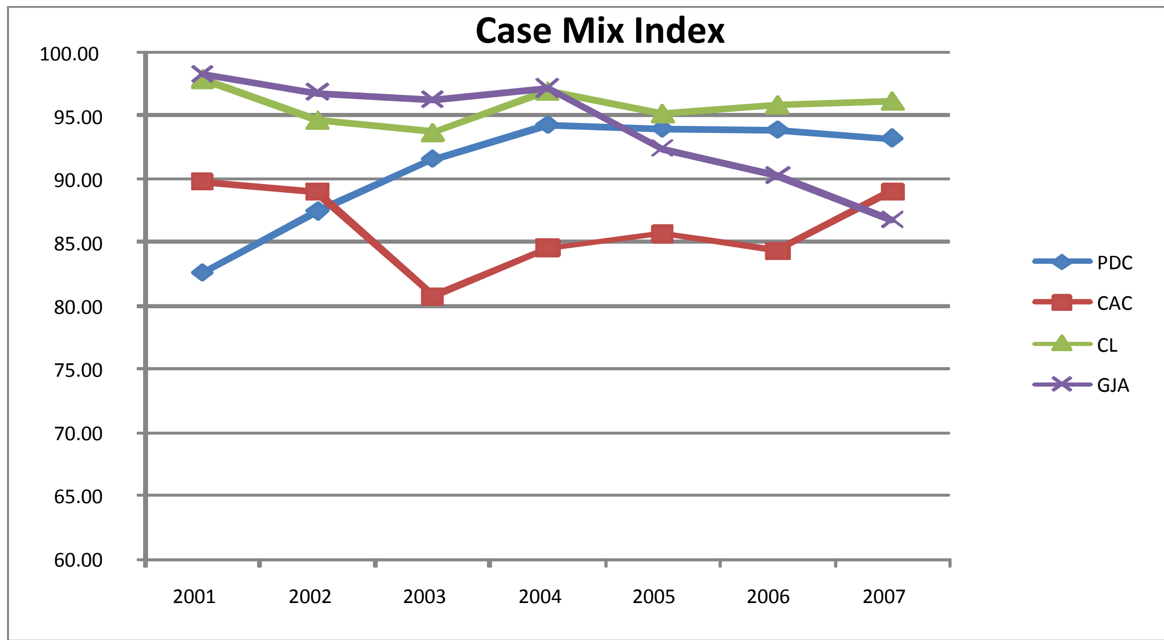
Management agrees with this recommendation. Both Financial Services and LTC staff are aware of and understand the eligibility of expenses within each funding envelope. Annual third party audits are performed on expenditures to ensure compliance with specified ministry guidelines. Increased reporting and analysis of expenses within the funding envelopes will be undertaken by the branch, in conjunction with Financial Services, and will be implemented by Q2 2009.

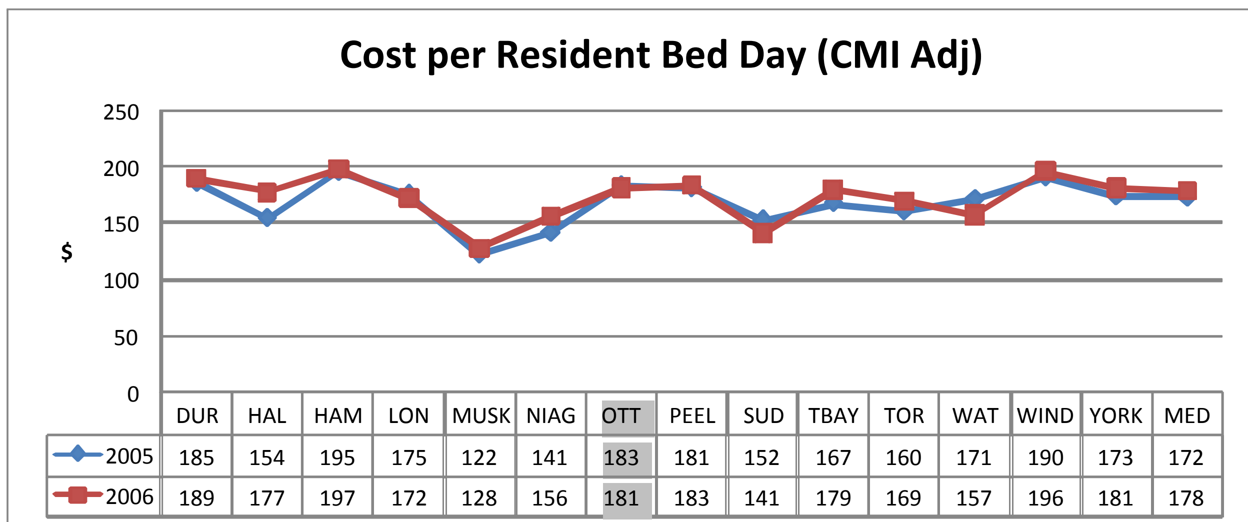
Case Mix Measure and Case Mix Index

The Case Mix Measure (CMM) is determined by the resident classification process. The Case Mix Index is calculated from the Case Mix Measure. The Case Mix Index (CMI) is used to express the level of care requirements of each home, and represents the basis upon which funding in the Nursing and Personal Care envelope for each home is established. Appendix A contains a more detailed discussion of the CMM/CMI system and how it determines the funding received by each home.

The CMM and CMI for each home is shown below as well as the cost per resident day adjusted for CMI for the OMBI participants.







	DUR	HAL	HAM	LON	MUSK	NIAG	OTT	PEEL	SUD	TBAY	TOR	WAT	WIND	YORK	MED
2005	185	154	195	175	122	141	183	181	152	167	160	171	190	173	172
2006	189	177	197	172	128	156	181	183	141	179	169	157	196	181	178

Source: 2006 OMBI Performance Benchmark Report

The CMM for each of the homes is low in comparison to other homes in the OMBI group. As the classification of resident acuity is solely based upon documentation, there is a potential opportunity to increase the CMI with fully computerization resident care documentation system.

The LTC Branch is in the process of implementing Goldcare Resident Care Planning Module. It currently uses Goldcare for its trust accounting and accommodation billings so there will be integration for basic resident data. Generally, the implementation has been viewed as a success with the exception of connectivity issues at Carleton Lodge. However, there was no evidence of a project plan for implementation of the Goldcare system other than that provided by the vendor.

The project plan provided from the vendor focussed primarily on the software and less on the new business processes which will be required for successful implementation. A comprehensive project plan is required for the Goldcare implementation. Such a plan should include key milestones and deliverables, as well as regular reporting on its status, results and training activities. Years to payback of the system should be specified and this should be reported to City Council on a regular basis to show the advantages of implementing technology.

The CMM is an important indicator not just for funding but also resource allocation between homes and within the homes. Proper documentation is the key to developing proper CMMs which is the goal of the Goldcare implementation.

Recommendation 21

That the Branch develop a comprehensive project plan for the Goldcare implementation with key milestones and deliverables, including regular reporting on its status, results and training activities as well as specifying years to payback of the system.

Management Response

Management agrees with this recommendation and a project plan, developed by the branch, IT and the vendor is currently in place.

A project plan has been in place since the project started for ongoing implementation and development. A branch steering committee and user group were established post implementation (Q4 2008). These teams meet on a quarterly and monthly basis as per their respective terms of reference to address emerging issues and to identify new opportunities as the software version upgrades are introduced. Status reports are provided as part of the standing agenda items to the branch management team.

Recommendation 22

That the Branch benchmark their Case Mix Measure prior to the implementation of Goldcare including the subsidy against post Goldcare implementation.

Management Response

Management agrees with this recommendation and it is current practice. The LTC branch has tracked the Case Mix Index and Case Mix Measure across the four homes for the past seven years and has continued to do so following the first phase of Goldcare implementation, which was completed in May 2008. This documentation is distributed to administrators and managers of Resident Care annually. Of note, is that as of Q4 2009 CMI will no longer be used to evaluate residents in LTC homes. This program conversion is in phase 6 of a provincial conversion to the Resident Assessment Instrument-Minimum Data Set (RAI-

MDS). City homes will be participating in the provincial RAI-MDS program and will no longer receive CMI and CMM results.

Other MOHLTC Funding

The MOHLTC provides funding for lab expenses and high intensity needs for residents at a 100% reimbursement. These programs require that the home complete a claim form and provide a copy of the receipts. These claims are to be submitted quarterly.

The lab submissions for all homes were complete and reconciled by the FSU. Reconciliation of these claims to the MOHLTC Monthly payment notices was achieved. However, it was unclear if these submissions were accrued upon submission.

The FSU was unable to provide the High Intensity Needs Claims as they reside at each home. When questioned how they reconciled these claims to the actual subsidy received, they indicated that they did not do this. However, the subsidies are tracked in the general ledger. The auditors were unable to reconcile the lab and high intensity needs submissions to the general ledger and/or the LTC Facility Report submitted to the MOHLTC. The FSU indicated that this was not simple to accomplish nor were they clear as to whether or not claims were accrued receivables. It was noted, however, that there was no evidence of claims being made for any supplemental staffing hours for high intensity needs. This is an eligible expense if approved by MOHLTC and could be a source of revenue for the City upon examination.

With respect to other grant opportunities, the City has been successful in receiving grants for the Late Career initiative. However, the City has not received funding for the New Graduate or Mentorship Strategy programs. It was unclear from the documentation if these had been applied for. As well, not all homes undertake to gain these funds nor is there a centralized approach to apply for these funds. These applications are held by the Branch and not sent to the FSU and therefore not accrued. Revenues are recognized upon receipt. Some of these grant programs require funding commitments from the operator. As such, the LTC Branch may wish to consider to addressing during the budget process.

Recommendation 23

That the Branch forward a copy of the High Intensity Needs claims to the FSU in order to improve accounts receivable practices and allow for proper reconciliation.

Management Response

Management agrees with this recommendation. A process for reconciliation of High Intensity Needs claims against Ministry revenue was developed and

implemented as part of the first phase of Goldcare implementation, which was completed in May 2008.

Recommendation 24

That the Branch review the High Intensity Needs policy against internal practice to determine if there are additional cost recovery opportunities for the home.

Management Response

Management agrees with this recommendation. The branch conducts this practice on an annual basis to ensure all cost recovery opportunities are maximized. This practice will be documented in the Q1 2009 review of the terms of reference for the functional teams.

Recommendation 25

That the Branch coordinate grant program submissions and assist home management with the response.

Management Response

Management agrees with this recommendation and it is current practice. The ongoing practice is to coordinate grant submissions through the LTC branch management team. This practice was introduced in 2004 to maximize the homes' ability to access newly announced funds through the provincial nursing strategy. Upcoming funding opportunities are discussed at branch management team, an administrator is selected to coordinate the application on behalf of the branch and a central application is submitted. In some cases the Ministry of Health and Long Term Care requires an individual home submission and this requirement is assessed with each new funding opportunity. This process has continued since 2004 and is now used for other central applications, such as research due to the success the branch achieved in accessing funds with a centralized process.

Allocated Administration

As part of the administration envelope, the City is eligible to claim allocated administration costs. In interviews with managers and the FSU, it was evident that there is limited knowledge of the methodology used for the allocation of administration other than the FSU costs. RPAM allocates costs as well based upon a formula but there is little understanding how these costs are calculated and reported to MOHLTC. However, the Annual Facility Reports are audited by the City's external auditors. Further, allocated administration costs amount to 3.3% of the total expenditures. Total Administration costs amount to 11% (without debt). This is in line with industry standards.

An MOHLTC compliance audit may request that the Branch provide the methodology and calculation of allocated administration. As this is not specifically documented, subsidies could be at risk. However, even without allocated

administration costs, the City is over its funding envelope for administration. Therefore, if this was determined to be an ineligible expense, it would not result in a loss of subsidy. It is important to note, however, that the true cost of providing services is unknown without understanding the allocated administration methodology.

Recommendation 26

That the Branch determine the appropriateness of the allocated costs, document the method of allocated administration costs and ensure that proper documentation is available for audit.

Management Response

Management agrees with this recommendation. Costs are allocated as per Financial Information Return (FIR) guidelines. The allocation methodology will be documented and kept on file for LTC staff and future audit requirements. This will be implemented by Q3 2009.

6.2.3 Financial Audit Objective 3

To assess the effectiveness of the internal control framework as it relates to the management of the resident trust accounts.

Audit Criteria

- The transactions within the trust account reflect the resident admission agreement with the City and are congruent with MOHLTC standards for trust management.
- The policies and procedures with respect to management of trust accounts define roles, responsibilities and reporting mechanisms. Internal controls are documented and adhered to.
- Resident trust issues are dealt with in timely, efficient and effective manner.
- Regular reconciliations are performed of the trust account and petty cash floats in the homes. Appropriate segregation of duties exists to safeguard resident funds.

Observations

A trust account is for the convenience of residents who need to have funds maintained in a safe place and readily available for use in the long term care facility. Funds in the trust account may be used to pay for facility-related transactions approved by a resident/authorized representative, such as payment of accommodation costs as well as other optional services. All long term care facilities are required by legislation to provide a trust account for residents' personal needs funds, for those residents who may wish to use this service. Regulations governing trust funds are found the Homes for the Aged and Rest Homes Act. These

regulations specify the requirements that must be met with respect to the management of funds that have been entrusted to a facility for management.

The City is managing a trust on behalf of up to 711 residents at any given time. Although the dollar value is not material, it is important to note that these funds are not City funds. Therefore, the standard of care needs to be at its highest. As per the MOHLTC program standards:

> *"Residents' trust accounts must be managed according to the provisions of the Trustee Act, April 1995. These funds must be held in interest bearing accounts and each account must accrue interest based upon a set calculation policy. The facility must establish policies for management of the trust accounts, including but not limited to the following:*
>
> - *a system to record authorization for charges that the resident/representative directs the facility to be paid from his/her trust account*
> - *charges for the administration of the trust account*
> - *hours when trust account funds are available*
> - *amounts that may be withdrawn in cash, and notice that is required for larger withdrawals*
> - *records management.*
>
> *Residents' trust accounts cannot be billed for any charges that are not authorized by the resident/authorized representative in writing and that are not in accordance with legislation. Each withdrawal from a trust account must be authorized in writing by the individual resident/authorized representative. This can be done at the time each withdrawal is requested by the resident/authorized representative. Authorization can also be provided on a schedule which is part of the admission agreement (with any later changes in direction initialled and dated). In this way, a resident may pre-authorize withdrawals for such items as accommodation charges or optional charges to be paid on a regular basis.*
>
> *The administrator shall maintain a separate, detailed record for each resident's trust account. This record shall be retained for at least six years from the date the trust account is closed or becomes inactive, showing the date and amounts of all deposits and withdrawals.*
>
> *Any complaints from the resident/authorized representative or other person, about the handling of residents' personal funds will be investigated by the Ministry of Health staff."*

Resident Trust Accounting

All resident billings and trust accounting is performed by the FSU. The staff at the Branch and homes have little interaction with the financial transactions of the residents other than disbursement of trust funds and meal tickets. It is important to

note that under regulation O.Reg 157/08 of the Homes for the Aged and Rest Homes Act, section 5, Powers and Duties of Administrators, states that an administrator *"is responsible for the receipt from, and the disbursement to, residents of money held for residents in the trust account established under section 53 and for keeping a written record of all those receipts and disbursements."* Although this does not mean or imply that the administrator must perform these duties, the administrator is responsible for the trust accounts. As the FSU performs these functions and there is little to no oversight by the administrator or Director of the Branch, the administrator currently does not take on that responsibility. The effort to segregate duties between the FSU and the homes has resulted in the administrator not having the ability to exercise his/her regulatory responsibilities in trust management.

Documentation provided for charges to the trusts was not consistent and not complete. As well, resident files were incomplete and unorganized. In particular, there was little back-up documentation in the files and it was clear that the administrator(s) did not review these files.

At the homes, staff indicated that they had limited understanding of the process or the program standards with respect to trusts. The files reviewed were incomplete and charges to the residents were often not documented in the resident file. There was no evidence that any file management policies existed that outline the requirements for documentation or appropriate charges.

A comprehensive set of policies for the management of trust accounting is required. These policies should be reflective of MOHLTC program standards, provincial regulations. The policies should be supplemented by detailed procedures and file management/documentation requirements. Accountabilities and responsibilities of the Branch and FSU should be clearly defined. The admission agreement should be reviewed and updated to include an area to charge accommodation fees to the trust, as well as all other fees, with approvals indicated by residents' initials. An annual review process should also be undertaken for each resident/family to ensure that the fees charged to the trust are agreed to. Closed files should be done systematically. A checklist should be developed to ensure files are opened and closed accurately and timely. Files should contain all documentation of the resident including all trust and accommodations transactions as well as tax information (e.g., T5s, receipts etc).

Trust Agreement

The admission agreement includes a section whereby the resident authorizes the creation of the trust and the services that can be charged to the trust. It should be noted, that although residents may elect to have their accommodation charged to their trust account on a monthly basis, the trust agreement does not have this listed as an option to be authorized.

The trust agreement is changed annually to reflect the rates. Changes in rates are communicated to residents and/or alternate decision makers via written letters. This portion of the admission agreement is sent to the FSU for processing.

Recent changes were made to the trust section of the agreement. Up until 2005, the resident was required to initial beside the service and rates that were agreed to be charged to the trust account. The current agreement simply requires a signature at the bottom of the list. Further, as mentioned above, there is no provision in the current admission agreement to allow the City to charge accommodation fees to the trust account. Therefore, there is no indication of the authorized charges.

It is important to note as well that although the admission agreements are changed annually, the social workers did not ensure that the most current agreement was utilized. In one home, the admission agreement varied for new admissions in the same month by the same social worker. The rates for trust services that were approved were inaccurate, representing old rates. This indicates a lack of control over processes and financial quality assurance.

Trust Account Charges

All charges to the trust accounts are entered by the FSU based upon information from the homes. Currently, there is little mechanism to interact with the FSU and the staff who administer the resident accounts. Although generally, individual transactions were authorized at the home, there were no checks in place to ensure that the charges were authorized to be charged to the trust.

The admission agreement is silent on charging of family meals or any meals. However, there were several charges for lunches and meals for families. It is a known practice to charge such things to the trust account and yet, the admission agreement is silent. The staff in the homes provide services such as meal tickets, withdrawals, deposits, hairdressing, foot care, etc. However, the only access to the trust account information through Goldcare is the balance in the resident account. Staff therefore do not have access to the list of approved services that can be charged to the trust account. Further, it is possible for the resident to overcharge the trust as the information on the system is incumbent on entries by the FSU and the staff in the homes do not know what has been charged in other parts of the home nor do they know the time lag for entries.

In reviewing resident files, there were many charges to the trust accounts that did not have documentation to support the charge. Further, the files were incomplete and there was a lack of annual processes to update resident financial profiles. This could lead to misunderstanding of fees charged, and of authorizations for trust charges and accommodations. It is important to note, however, that although documentation is weak, there was no evidence of complaints that the charges were not authorized at the time of service.

The trust accounting and accommodation procedures have not been clearly developed with the LTC Branch. Since, under regulation, the administrator of the home is considered responsible for the management of the trusts and the City is acting as Trustee, the lack of formalized processes as well as poor documentation controls is a risk, not simply for the MOHLTC audit but potential concerns for residents.

As per MOHLTC program standards, the trust accounts must be audited by a professional accountant licensed under the Public Accountancy Act. The City's external auditor has audited the trust accounts and has provided an unqualified audit opinion in all years. Documentation issues have not been raised by the external auditor. However, it is important to note that external auditor opinions are based upon an expression of materiality. In the context of the City, any trust accounting issues are likely immaterial.

That being said, should a MOHLTC audit occur with respect to trust accounts, the City could lead to a compliance order. Further, a complaint from family members may occur. Improper documentation could lead to losses for the City, as they likely would be responsible for any charges not authorized.

Most importantly, inappropriate charges could lead to disputes between the resident/family and the City which may ultimately lead to the City being held responsible.

Complaint Mechanism

As with any program standard, residents and families could lodge a complaint with MOHLTC regarding trust management. The complaint mechanisms are outlined on most boards in the homes. However, this is not addressed in the admission agreements nor is a review undertaken to update the admission agreement and the various pricing. To date, there have not been documented complaints nor do the residents have a direct link to those in the FSU upon admission.

The resident and family surveys have limited questions (two) for financial and trust accounting management. These have favourable results. However, the questions are vague and do not ask specific questions regarding the "financial experience." The survey currently used by the LTC Branch came from OMBI. There is a belief that it cannot be expanded. As well, the FSU has not been involved in the development or the analysis of the resident and family surveys. There is little interaction between residents/families and the FSU. No tracking of disputes is undertaken and surveys do not reflect the FSU services.

Trust Reconciliations

Reconciliations of the trust account are completed each month at which time account closeouts and interest is allocated. The staff at the homes perform reconciliations of the petty cash float for the trust account twice a month. The petty cash policy is well documented and followed by staff and the FSU. There are good

controls over the cash including lock boxes and utilization of safes. However, the control over cheques issued from the FSU could be improved. Signed cheques were found to be in open view within the FSU.

It should be noted, as well, that the MOHLTC program standard allows the home to charge to manage its accounts on their behalf up to $5 per month. The City does not currently charge for this service.

Interest Revenues and Allocation

The MOHLTC program standards require that the home invest the trust funds in an interest bearing account and that the interest be allocated on a consistent method. The accounts currently are earning less than 3% interest which is a poor rate of return given the size of the City. With respect to interest allocation interest is calculated at the lowest level in the month which is calculated monthly by Goldcare. There is no policy that outlines the method of allocation.

Although the City is in compliance with the program standards, the residents and families could have a complaint that the City is not investing the trust funds to the best available rates or that the interest allocation method is inappropriate.

Recommendation 27

That the Branch, in concert with the FSU, develop policies and procedures for the management of trust accounting that are reflective of MOHLTC program standards and provincial legislation and regulations and which clearly define the accountabilities and responsibilities of the Branch and the FSU.

Management Response

Management agrees with this recommendation. LTC and the FSU currently comply with policies and procedures regulated under the Homes for the Aged and Rest Homes Act. Each year a third party financial audit is conducted to ensure compliance with specified ministry guidelines.

Financial Services and LTC will formalize and document current policies and procedures by Q4 2009.

Recommendation 28

That the Branch update the admission agreement to include charges of accommodation fees to the trust, as well as all other fees, authorized by residents' initials.

Management Response

Management agrees with this recommendation. Prior to this review, the admission agreement listed the services provided by LTC which the resident or power of attorney accepted as a whole. The admission agreement has now been updated to include areas adjacent to each service to be initialled upon admission.

Recommendation 29

That an annual review process be undertaken for each resident/family to ensure that the fees charged to the trust are agreed to.

Management Response

Management agrees with this recommendation. Currently, each resident/family receives a monthly statement outlining balance remaining, fees charged and closing balance of their trust account. In addition, commencing for the 2008 year-end, Financial Services will provide a consolidated annual statement for review.

Recommendation 30

That, at least annually, residents and families be surveyed on their financial experience in order to assess client service of the FSU.

Management Response

Management agrees with this recommendation. This is incorporated in the annual resident satisfaction survey that has been undertaken since 2001 as part of the OMBI reporting process.

Recommendation 31

That Management review the interest policy for trust accounts to determine if there are some increased interest income opportunities for residents.

Management Response

Management agrees with this recommendation. The Homes for the Aged and Rest Home Act (Regulation 637) limits the type of investments that trust accounts can enter into as it requires that funds are accessible by residents at all times. The resident trust accounts meet the requirements to have funds on demand and currently generate a return of prime less 1.75%, which is the most competitive rate on the market, as confirmed with the City's financial institution.

Recommendation 32

That Management review the signing authority with respect to the trust and the practice of closing off trust accounts and that improved controls over cheques be implemented.

Management Response

Management agrees with this recommendation. Signing authority for trust accounts has been implemented and forms part of the admission agreement.

The Auditor General states that control over cheques issued could be improved as cheques were found to be in open view. Financial Services operates in a secured area and cheques are locked away when not in use.

6.2.4 Financial Audit Objective 4

To evaluate the effectiveness of the budget process in order to meet departmental and home based goals, objectives and legislated requirements over time.

Audit Criteria

- Budgets are aligned with the strategic and business plans. Project costing is utilized.
- Budgets are developed through the involvement of managers, administrators and directors based on their accountability.
- Efficiency targets are developed within the Branch and home to meet overall City reductions. In particular, strategies for efficiencies in envelopes where taxation (net levy) supports the operations of the homes are explored.
- Budgets are developed on an annual and multi-year basis in conjunction with the long-range financial plan.
- Budgets are developed on an envelope per resident per day basis.
- Budgets are comprehensive and reflect full cost of operations.
- Budget variance analyses are performed on a regular in year basis and explained by the responsible manager. Strategies are developed in a timely fashion to deal with deficits and surpluses.
- In year and annualized forecasts are undertaken and inform decision-making. Forecasts are linked to goals and objectives and are adjusted as required.

Observations

Budget Development

As per O.Reg 157/08 as amended, a regulation prescribed under the Homes for the Aged and Rest Homes Act, the administrator of a municipal home has the duties and is responsible for the purchases for the home as well as capital expenditure submissions to the MOHLTC. As well, from a best practices perspective, the development of budgets should be delegated to the lowest appropriate level of the organization in order to promote accountability and sense of ownership. The knowledge of risks and requirements of the home is most likely to be most understood at the managerial level. The more involved that managers and staff are in the budgetary process, the more likely they are to find efficiencies and best value for tax dollars. That being said, budget processes also need to include guidelines and instructions from the corporation so that a horizontal as well as vertical budgetary approach is taken. It is well known that current needs of all municipal services exceed funds available or taxation levels.

In the LTC Branch, budgets are developed as a team. However, there is a general sense that little flexibility is provided to administrators. Budget guidelines are

developed through the Financial Services and provided to the Branch. Most managers expressed concern over the lack of funding for long term care as well as the centralized approach to budgeting in the City. Capital planning is based upon a set allocation rather than need and yet, some of the homes are entering periods whereby their equipment and assets are aging beyond their useful lives. Management were not aware of any long-range capital plan for the LTC Branch nor does it seem that there is significant knowledge of related PSAB changes that are required to be put in place by end of 2008.

With respect to a full costing approach, the Branch does not utilize any form of activity based or project costing. Further, although the City has made a significant investment in SAP, the financial systems do not have the functionality required to undertake project costing at this point. As such, full cost of providing services is not undertaken at the Branch and there is no mechanism to determine the efficiency of equipment or other assets.

In general, the City and the Branch continue to operate in a top down approach to budget development. Although the City undertook a very comprehensive Long Range Financial Plan, it has not resonated into long term and/or multi year budgets within branches for operating or capital.

The risk of a top down budget approach is the lack of accountability, budgets based upon inadequate knowledge of the organization, risk to residents due to under funding and lack of long term budgets. Although there is an annual process to review and reduce costs, they are not based upon needs. For example, the Branch is given a reduction strategy target which includes a non-replacement (gapping) requirement. This has not been developed on a particular basis with an understanding of the impacts. However, managers have developed ways in which to meet these funding gaps. Issues with the current gapping strategy have been discussed earlier in this report.

Operating budgets are developed on annual basis only. Capital budgets are developed on a longer-term basis but funding is still developed on an annual basis.

There is little concentration on the revenue side of the Statement of Operations nor is there a process to assess areas where revenues could be increased in order to provide more funding and cost recovery for the homes. Budgets are calculated on a resident/day basis. The key metrics produced by the LTC Branch are produced on this basis as well.

The per diem rates provided by MOHLTC on are on per resident/day basis. The preparation of budgets on this basis provides ease in comparison of actual and budgets. It is unclear from the evidence if these can be accessed by managers. However, electronic copies are sent to managers regularly.

Budget Variance Analysis, Forecasting and Reporting

The Branch and FSU both provide monthly and annual information to managers. Furthermore, managers have been trained to access information from the corporate Financial System (SAP). All managers expressed satisfaction with the reporting framework. However, it was apparent that the systems did not provide the information required to make financial decisions. The managers rely on the Branch and FSU to provide analysis and forecasts. However, managers perform monthly financial reviews and report to their administrators. These results are discussed at management meetings whereby issues flow to Branch management.

The City and Branch have not embraced the full Public Performance Framework in that little has been done to link financial results with non-financial results[2]. Goals and objectives could be at risk without timely and relevant financial statements and forecasts. Many non-financial metrics are provided by the Branch through Balanced Scorecard metrics. The managers do not have direct, online access to these measures.

Recommendation 33

That the Branch review its accountability framework as it relates to financial requirements and move to an integrated budgeting approach in conjunction with the CPS Department and City as a whole.

Management Response

Management disagrees with this recommendation. The Auditor General has concluded that Corporate Finance provides guidelines and parameters for budgets and this practice leaves fewer opportunities for decision-making at the branch level. Management receives budget guidelines and parameters from City Council, not Corporate Finance. Yearly targets are identified through the branch hierarchy and are then reviewed at a branch/departmental level prior to being presented in the draft budget.

The Long Range Financial Plan also allows the branch to identify required needs within the City Operations department and the City as a whole.

Recommendation 34

That the Branch undertake an annual review be to assess potential efficiencies as well as revenue opportunities.

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[2] PSAB's Public Performance Reporting outlines recommended practices for public sector performance reporting. This has been utilized in the other levels of government for some time to reflect financial and non-financial results.

Management Response

Management agrees with this recommendation. An annual efficiency review is current practice. The first review was conducted through the Branch Process Review Program (BPRP) process in 2007 and included external benchmarking. LTC is currently concluding its second annual review through a Strategic Branch Review (SBR), which will be completed by the end of Q4 2008.

Recommendation 35

That the Branch move towards multi-year budgets taking life cycle costs and long term cost of capital into account in conjunction with PSAB compliance.

Management Response

Management agrees with this recommendation. LTC, along with all City branches participate in the annual budget process. Multi-year capital budgeting including lifecycle costing has been the practice since the City amalgamated and multi-year operating budgets were introduced in 2008.

Recommendation 36

That Branch operating budgets continue to be prepared on a per resident per day basis and that results be monitored for both expenses and revenues on that basis.

Management Response

Management agrees with this recommendation. The current practice is to prepare operating reports on a per resident per day basis so that results are monitored for both expenditures and revenues.

Recommendation 37

That Branch capital budgets be prepared on a life cycle cost basis to ensure that all costs are included in every capital project.

Management Response

Management agrees with this recommendation. While LTC receives a set allocation for minor capital, a lifecycle approach linked with the homes' preventative maintenance program, is used to identify capital replacement priorities across the four homes. These include: medical equipment, furniture, kitchen equipment, etc.

Recommendation 38

That the Branch and FSU collaborate to develop useful and timely variance reporting.

Management Response

Management agrees with this recommendation. Current practice is to provide monthly operating and capital reporting and ad hoc variance reporting as required. Financial Services will continue to review and develop the reports provided to ensure their effectiveness.

6.2.5 Financial Audit Objective 5

To assess the effectiveness of the control framework and risk management practices.

Audit Criteria

- Policies and procedures related to purchasing, cash handling, bank reconciliation, travel, accounts receivable and payroll are clear, understood and practiced throughout the Branch and homes.
- Internal Control Policy Framework includes such controls as mandatory vacations, rotation of duties and training. Policies are adhered to by all sections of the Branch.
- Policies and procedures ensure that Tangible Capital Assets (TCA) and consumable inventory are safeguarded and managed with probity and prudence.
- Appropriate segregation of duties is evident and documented in policies and procedures.

Observations

Internal Control Framework

Most homes do not handle significant cash and the cash handling controls observed at the homes are adequate. Family meal tickets are issued from reception and funds transferred to the FSU. As well, all other payments, including cheques received from residents, are transferred via locked box with an email reconciliation on the 15th and 30th of each month.

All bank reconciliation processes are undertaken by the FSU for the trust accounts on a monthly basis. All other transactions are also processed through the FSU except for payroll which is processed through the scheduling coordinator. Internal controls are strong for processing payables. However, there is no accounts receivable policy at the Branch, FSU or City level that could be accessed nor was known by any staff interviewed. This represents a control weakness as staff do not recognize the potential receivables that should be accrued, nor are finance fees charged on overdue accounts.

There are some weaknesses in payroll processing as it is based upon the work schedule. There is currently no connection between the access cards and payroll. The staff report to the charge registered nurse. If the person is late, the practice is

that they are still paid except in unusual circumstances. However, the implementation of the Telestaff software for scheduling should improve the payroll controls. When interviewed, some managers indicated that the idea of linking access cards to payroll with the implementation of Telestaff was a union issue. In some communications, it was presented that management would not use the access cards in this manner in order to appease the union's concerns.

With respect to rotation of duties, back-up provisions and mandatory vacation policies, the Branch has not implemented these controls specifically. However, there are sufficient resources to ensure vacation coverage of administrative positions. At the FSU, there are back-up resources for billings and trust accounting. However, the staff have been assigned to two homes each. Therefore, there are some internal control risks as all the transactions for a particular resident are performed by one person.

Tangible Capital Assets (TCA)

By January 2009, all Canadian municipalities must move to full accrual based accounting in order to comply with the accounting standards set by the PSAB, the standard setter for the public sector in Canada. PSAB has adopted these new standards which require significant changes to the municipal financial statements with the inclusion of all non-financial assets. The most significant change is the requirement to capitalize TCAs and amortize the historical cost over the useful life of the asset. In other words, the cost of TCAs is expensed over their useful lives and the historical cost of their utilization is recognized accordingly. These new standards are outlined in PS3150. Currently, under cash (or modified accrual) basis of accounting that is utilized by municipalities in Canada, the cost of TCAs is expensed when it is paid for. Further, the Branch has not implemented appropriate inventory valuation and controls over consumable inventories.

Based upon interviews and documentation, there was little understanding within the LTC Branch or the FSU regarding PSAB or the new reporting standard. There was a sense that this was a Financial Services responsibility. However, there are many changes that need to be made across the organization including general ledger and reporting changes. As well, the intention of PSAB is to improve controls over assets as well as promote asset management. Further, the MOHLTC program standards require that homes maintain lists of equipment and machinery as well as the values. It was evident that little communication regarding these new and vast changes have been communicated throughout the Branch or FSU and training has not occurred. When interviewed regarding corporate asset policies, staff referred to the Purchasing Policy. This policy does not address TCA or inventory controls. In response to the 2007 Audit of Inventory and Asset Management Processes, management indicated that each Department and Branch had implemented their own policies in this area.

Recommendation 39

That the Branch in conjunction with the FSU develop an internal control framework with a full range of control policies including accounts receivable, inventory and tangible capital assets.

Management Response

Management agrees with this recommendation. Corporate policies are being developed on an ongoing basis as part of the Financial Control Framework. Accounts receivable policies are in place, however, are not fully documented. Proper documentation will be implemented by Q3 2009. With respect to tangible capital assets (TCA), the branch has postponed a fixed asset review until the new TCA protocol has been developed. Once the TCA protocol has been implemented appropriate counts and itemization will occur. Finance will comply with the PSAB 3150 requirement, coming into effect on 1 January 2009, for reporting on 2009 financial statements by mid 2010.

Recommendation 40

That the Branch review its payroll and scheduling process to determine if access cards can assist in payroll reconciliation.

Management Response

Management agrees with this recommendation. LTC and Human Resources will review the payroll and scheduling process to determine if access cards can assist in payroll reconciliation by the end of Q3 2009.

6.2.6 Financial Audit Objective 6

To analyze the financial reports for relevance, reliability and comparability between years, homes and external benchmarks.

Audit Criteria

- Financial reports are timely, appropriately frequent and reflect management's requirements.
- A continuous improvement process is in place to allow financial statement users the forum to provide feedback report designer and financial analysts to ensure usefulness, completeness and integration with business requirements.

Observations

Reports are timely and provided to management monthly and on an as needed basis. As well, most managers interviewed had access to SAP and often accessed the financial system to drill down to various expenses and revenues. However, the lack of an inventory system and ability to track various costs as utilized were raised as a concern by some managers.

The FSU regularly designs and provides new and improved reports based upon needs. The reports were found to be too high level to do any real analysis and without SAP, the reports were not of sufficient detail to guide decision-making. However, in interviews with most managers, there were generally positive comments. Some administrators expressed a concern about the lack of detailed information with respect to monitoring the budget. Managers have tended to develop their own reports in order to manage including duplication of entry.

The move to full accrual accounting will change the structure and reporting requirements for the City. This should be anticipated and reports developed to assist managers in understanding the new world of accounting for municipalities.

Recommendation 41

That the Branch work with the FSU to improve financial reporting and ensure PSAB compliance.

Management Response

Management agrees with this recommendation. Financial Services will continue to provide monthly operating and capital reports and ad hoc variance reporting as required. Finance will comply with the PSAB 3150 requirement, coming into effect on 1 January 2009, for reporting on the 2009 financial statements by mid 2010. New reporting standards are currently being developed by Financial Services and training of appropriate staff has commenced.

6.2.7 Financial Audit Objective 7

To review current revenue streams and cost recovery structures to assess if revenue streams are maximized.

Audit Criteria

- Fees for service reflect full cost to provide service.
- Homes/Branch have a fundraising plan and donation account.
  Donations are managed and utilization based upon a documented policy.
  Receipts are issued for donations.

Observations

Hairdressing Services

In accordance with MOHLTC program standards, various services can be provided to residents at the home. One common service provided is hairdressing services. Each home currently has an in house hairdresser who earns $22.50 per hour. With benefits, that is approximately $29 per hour. The annual cost of the hairdresser is thus $52,000.

Listed below are the new hair care charges, which include GST. The current and proposed hairdressing rates are as follows:

	October 15, 2007	October 15, 2008
Cut Male/Female	$13.50	$16.00
Set	$13.50	$16.00
Set & Cut	$27.00	$32.00
Tint	$30.00	$35.00
Perm	$46.50	$55.00

The average uptake from residents is from $28,000 to $39,000 in fees which indicates that cost recoveries are not occurring. However, the LTC Branch has increased fees over the past two years to increase recoveries. It is important to note that the rate increases between 2007 and 2008 represents approximately an 18% increase. In a letter to the residents from the Manager of Recreation and Leisure, the following reasons were provided for the increase:

> *"On an annual basis the City of Ottawa Long Term Care Homes review fees for service to determine fair market value for services we provide. The current review identified a significant price difference in hair care services."*

Food Cost Recovery

The Branch does track costs and recoveries for meals. Although there is no expectation for full recovery, it is clear from the Branch reconciliation that these costs are not be covered. Food recovery rates likely have not been reviewed regularly and food costs have increased.

Donations

Donations are an acceptable and promoted method to raise funds for the homes. As a municipal home, it is a registered charity. These funds are an excellent way of providing enhanced services to residents and improve the quality of life in the home.

In the City of Ottawa homes, donations are minimal and fundraising is not a prime objective of the homes. Some donations are provided as endowments whereby specific purposes are identified. Unfortunately, due to the financial reporting mechanisms, the City has difficulty in segregating funds for a specific endowment. At the end of 2007, the City had approximately $127,000 in donation funds or $176 per resident.

Recommendation 42

That the Branch review the need to staff a full time hairdresser in each home and the possibility of a contracted service (respecting the collective agreement).

Management Response

Management agrees with this recommendation. The City has a collective agreement provision that prevents contracting out of this service. LTC and Human Resources will work with the union to explore the possibility of exempting this service from the contracting out provisions in the collective agreement.

Recommendation 43

That the Branch review the food costs and recovery rates for Meals on Wheels, family meals, etc. to determine the appropriate rates.

Management Response

Management agrees with this recommendation. An annual review and contract process is currently in place. The annual process involves a review of food costs in long term care and considers any provincial increases that have been made to raw food.

Recommendation 44

That the Branch review its fundraising activities to assess possible revenue sources on behalf of residents.

Management Response

Management disagrees with this recommendation. The homes do not have a fundraising role. However, commencing February 2009, LTC will have staff representation on the new Long Term Care Prosperity Fund Board of Directors. This is a new community-based initiative with the intent to leverage community funds for supplemental long term care programs.

6.3 PERFORMANCE

6.3.1 Performance Audit Objective 1

To evaluate the degree to which the homes respect the Resident Bill of Rights.

Audit Criteria

- Residents are provided the opportunity to be involved in decision making regarding their care plans and financial affairs.
- Family and Residents' Councils are supported by the home and residents have the opportunity to participate. Residents feel free to express concerns to Councils, staff, and management.
- The homes are safe and secure and incident-reporting process exists to address safety and security concerns.

Observations

Each of homes embodies a distinct culture but the commitment to residents and the quality of care and service delivered to them is shared across the Branch. In each home, there were numerous observations of resident-centred care and strong evidence that the homes, on the whole, adhere to the Residents Bill of Rights.

Resident Involvement in Decision Making

Residents have the right to participate in decisions that relate to the care they receive in LTC. To evaluate the degree to which the homes adhere to this right to participate, Branch policies specific to admissions and care planning were reviewed. There are appropriate policies that guide staff through both the admission and care planning processes. Nursing supervisors and registered nurses take responsibility to ensure these policies are followed.

Across the homes, the practices are consistent with the Branch policies with respect to care conferences and resident care planning. Through these forums, residents and their families have the opportunity for input into their care planning and financial affairs. Ward clerks organize the care conferences and communicate the logistics to residents, families and to each of the units involved. The care conferences are well attended at all homes. A particularly notable practice is that of the physicians' attendance at care conferences at some of the homes. This is an effective process.

Some inconsistencies between homes with respect to admission processes and documentation were observed. As discussed earlier, a review of randomly selected resident business files suggests that there are a number of outdated admission agreements. According to MOHLTC standards, an annual renewal of the resident admission agreement is required to ensure residents remain aware of and in agreement with the provisions of the agreement. Outdated admission agreement documentation on the financial affairs of residents suggests that the City may be exposed to challenges by residents.

A mechanism to ensure that the current admission agreement form is utilized for all new admissions across the homes is required and the FSU should implement quality assurance measures to review admission documentation received from the social workers from each home. As a best practice, the Branch might consider the implementation of an admission checklist to assist the social workers and FSU in ensuring documentation is complete and up to date. An annual review process of the resident business files should be undertaken and agreements updated each year as required including a full trust and accommodation statement.

Recommendation 45

That the Branch ensure the most current admission agreement form is utilized for all new admissions across the homes.

Management Response

Management agrees with this recommendation and will ensure compliance with the current policy to use the updated form available on Ozone. A process has been in place since 2007 whereby current agreements are posted on Ozone to ensure admission agreement forms are consistent across all four homes.

Recommendation 46

That the FSU implement quality assurance measures to review admission documentation received from the social workers from each home including an admission checklist to ensure documentation is complete and an annual review process of the resident business files with a full trust and accommodation statement.

Management Response

Management agrees with this recommendation. A process to ensure completeness of the resident business files has been implemented. As well, trust and accommodation statements will be placed on file annually.

Resident and Family/Friends Councils Participation

Resident Councils are in place in all homes; minutes are documented often with support from assigned staff. The home's managerial team reviews and responds to the minutes in a timely manner. As appropriate, management attends Residents' Council meetings by invitation. Resident Councils are well supported by the homes; there is active participation by Councils in a number of initiatives that have resulted in new safety measures, new programs, new communication mechanisms, etc.

Similarly, Family and Friends Councils are revered in the homes. These Councils have become very active in bringing about improvements to the living environment and daily experiences for residents at the homes. In some instances, the social worker interfaces with the Councils. Of particular note is the Branch effort to assemble key executive members of each Family Council at a joint meeting to help facilitate synergies between these resources in the homes.

Safety and Security

There are appropriate policies in place to direct staff as to safety and security practices. The homes are equipped with door security systems that are consistent with those used in most long term care environments. The homes have secure entries and exits and all utilize proximity cards. In all homes, restricted areas are not accessible without a proximity card, indicating security is adequate. The charge staff have portable telephones, which provide for ease of communication in emergency situations. RPAM staff are available on-site in each of the homes during regular hours and on call after hours to address any security concerns within their mandate. Staff are aware of the RPAM service.

Some residents have access cards that allow them to exit and enter their respective buildings at any time. There is no consistent mechanism to determine if the resident is suitable to be provided with these cards and/or understand the ramifications in the event of a lost card. It is unclear if there is an assessment process that would determine the suitability of card issuance. Controls regarding issuance and cancellation of cards by the designated staff are effective during regular business hours, however, charge staff were not consistently aware of the procedure that would allow for cancelling lost access cards after hours. It was believed that only the office staff were able to cancel cards during regular business hours. This could lead to a security breach, particularly during weekends.

In full recognition of the rationale for securing access at the front doors, the inability of residents and visitors to have unencumbered access to the vestibule, especially in inclement weather, may pose a certain degree of safety risk. This situation was observed at Carleton Lodge, Peter D. Clark Centre and Garry J. Armstrong.

Cameras were linked back to monitors in reception areas or nursing stations and are effective in recording activity. In most instances, placement of these cameras was appropriate. At Peter D. Clark Centre, there were no cameras near the basement laundry area. Although generally staff would not be working in the laundry at night, there could be staff alone in the area on occasion. In the tunnels between the home and the bungalows however, there are sufficient security measures in place.

Another potential security concern relates to the food service area at Peter D. Clark Centre. With no cameras operating in the remote loading dock area, any staff member from food service or another unit may be at risk at any given time. Furthermore, once vendors have entered this area of the home, they have access into the rest of the building.

Lighting in the parking lots of the four homes is adequate. As is standard practice in the industry, night staff were afforded designated safe parking areas. One area of potential risk may be at Peter D. Clark Centre where the parking spaces, although close to the entrance door, are located in the loading area.

Recommendation 47

That the Branch develop improved access card procedures, particularly with respect to the issuance of cards to residents/families and to the processes for after hours cancellation.

Management Response

Management disagrees with this recommendation. Effective procedures are currently in place with respect to access cards. In addition, there is a process in place for immediate cancellation of cards after hours. The Power of Attorney for personal care has the authority to contact the Home’s administrator to verbally

change the access hours for a card during a situation of end of life care. The facility charge nurse has the authority to contact the administrator or their designate to authorize a change in card access after hours as per policy and procedure (reference no. 750:25 Access cards – Families and Residents). This policy will be reviewed with staff in Q2 2009.

Recommendation 48

That the homes provide access to the vestibules of the buildings in a manner that does not compromise the security of the building.

Management Response

Management agrees with this recommendation. LTC has previously investigated this possibility with Corporate Security and will revisit it again in Q2 2009. To mitigate the potential risk to residents from exposure to heat or cold, an access card is required to exit the homes, thereby reducing the likelihood that a resident cannot regain entry to the building. Furthermore, a doorbell is presently in place that rings at reception or to the charge nurse's cell phone to allow for timely access.

Recommendation 49

That the Branch implement policies regarding vendor access in unsecured and/or unmonitored areas of the building including notification to reception when vendors are in the building.

Management Response

Management agrees with this recommendation and will ensure compliance with current policy. Current practice is that staff accompanies unauthorized vendors as indicated in (policy and procedure reference no. 700:21: Security – Salespeople, Contractors, Trades people).

Health and Safety

Workplace inspections are performed monthly by the Joint Health and Safety Committee (JHSC). The JHSC terms of reference indicates and the practice was confirmed that at each home the entire building is only inspected annually. Corporate health and safety policies may have lead the Branch to believe that it can perform full facility workplace inspections on an annual basis rather than monthly. This is an improper interpretation of section 9 of the Occupational Health and Safety Act.

Recommendation 50

That the Branch review its health and safety terms of reference in light of the stipulations for workplace inspections with the Occupational Health and Safety Act.

Management Response

Management agrees with this recommendation. A comprehensive review was completed in 2007 and LTC branch practices were found to be compliant. As part of the regular review process, Occupational Health and Safety will review the terms of reference with LTC and will recommend and/or complete a revision where required, by the end of Q2 2009.

6.3.2 Performance Audit Objective 2

To evaluate the business planning process for effectiveness in setting and achieving goals and objectives.

Audit Criteria

- Strategic Vision and Plan for the City, Community and Protective Services and LTC Branch is understood and supported by a solid business/strategic plan.
- Business/strategic plans are developed and reviewed every 3-5 years.
- Business plans and departmental/home plans are aligned to the strategic plans.
- Goals and Objectives are clearly defined with key performance indicators with a regular reporting structure to measure results.
- Results, expected outcomes and ultimate outcomes are clearly defined in relation to the mission of the organization.
- The organization uses performance information in its strategic planning and annual Branch planning and vertical planning processes.
- The indicators used in the Long Term Care Balanced Scorecard are relevant and are reflected in the strategic goals. Regular reviews of indicators are undertaken to ensure continued relevance.
- The Balance Scorecard results are consistently produced in a timely manner in order to inform decision-making.

Observations

Home-Specific Business Plan Alignment with Higher Tier Plans

There are mechanisms that support sound vertical planning within the Branch and its homes. The annual LTC Branch plan is developed with input from the management staff of the four homes. This plan acts as the framework from which home-specific and their respective departmental plans are established. There is a fairly solid understanding amongst the managers about the interface between the Branch plan and their home-specific work plans. However, these managers have a far more limited appreciation of the relationship or linkage between the City's Strategic Plan, the CPS Strategic Plan, the LTC Branch and their home-specific plans.

Staff of different classifications and units across the four homes are aware that a Mission, Vision and Values document exists. While they were not able, for the most part, to recite the mission, vision or values, they were able to articulate the general principles and identify where they would find the reference material in the building.

Recommendation 51

That during the next round of strategic planning for CPS, the Branch take on a more active role to ensure the vision of the Branch is reflected in the CPS Plan.

Management Response

Management disagrees with this recommendation. LTC is actively involved in departmental planning and believes that the branch vision is adequately reflected in the City Operation department's plan. Since 2001, LTC has had a strong focus on resident/customer satisfaction. Both the departmental and corporate plans reflect this vision.

Business Plan Development

Home-specific work plans are developed by the senior management teams on an annual basis. These work plans are generated on the basis of the direction provided by the LTC Branch annual plan as well as the review of the Balanced Scorecard performance indicator results. Overall, the home and departmental business plans are in line with the Branch plans. Although there is no formalized results-based management framework (i.e., inclusive of results, expected outcomes and ultimate outcomes) the Branch's mission, vision and values guide the activities across all homes, corporate office and the supporting COEs.

There is significant variation in the comprehensiveness and rigour of the home-specific plans as well as the utilization of indicators to guide decision-making and dissemination of information. It is understood that the impact of substantial turnover in management positions in certain homes has had an impact on the quality of the long term planning. However, with the recently established stability, many future directed changes are being successfully put into place, especially at Carleton Lodge.

Training on business planning development, analysis and measurement would enhance the skills of various management and staff. Quarterly reviews of the business and departmental plans should be analyzed and disseminated to key stakeholders. Variance analyses should be undertaken to ensure early corrective actions.

Recommendation 52

That the business planning processes, reporting mechanisms and business plan format used by the Branch and homes be standardized, including quarterly

reviews of the business and departmental plans and variance analyses to ensure early corrective actions.

Management Response

Management agrees with this recommendation. This process is already in place, has been supported by the FSU since 2006 and will be formally documented by Q3 2009 to ensure consistent practice.

Performance Measurement

The Branch's plan serves as the guide for the development of the Balance Scorecard performance measures. The measures are designed and organized to meet the four pillars of the Branch's plan. Each year the Branch reviews these measures to determine their continued appropriateness. The Branch also reports performance based upon the OMBI key performance indicators that were developed in collaboration amongst the major cities of the Province.

Many of the performance measures are relatively new or have been tracked for only a short period of time. Most benchmarks that have been chosen have been developed internally and their sources are not documented.

The brevity of performance measurement makes it difficult to analyze success or trends over time. This opportunity to undertake trends analysis will evolve with continued commitment to the program. Although management indicated that it utilizes these measures in developing new plans, there is little analysis that has been documented. It is also important to note that most of the performance measures are produced by the Branch through data manipulation from various sources, such as SAP. These measurements are not easily accessible in real-time through business intelligence dashboards.

The indicators in the Balanced Scorecard are generally useful and are utilized to make decisions, monitor results and implement quality improvement plans. In some instances, the indicators are utilized to guide practice decisions, change policies and implement best practices, for example, the falls program in Garry J. Armstrong. It should be noted that recent changes in leadership in some homes has resulted in an elevated understanding and utilization of key indicators to guide delivery of care and services. Managers find the current indicators useful but stated that they would like to see additional indicators to assist decision making especially indicators that can be "drilled down" to the home-specific and RHA-specific levels. There are limited staffing indicators in the Scorecard from which to assess the effectiveness and efficiency of the Service Delivery Model. The FSU has attempted to provide this type of information but recognizes that some work still needs to be done. The implementation of Telestaff may provide additional information in this regard.

The homes are utilizing benchmarking to drive individual plans. The OMBI benchmarks are being utilized but these were questioned for validity by some managers. These benchmarks are currently being evaluated by OMBI as well.

The Balanced Scorecard information is timely and accessible to the homes. The introduction of electronic results has improved the timeliness of the indicator reports. The LTC Branch staff responsible for the development and reporting of the Balanced Scorecard Indicators are more than willing to add and/or adjust the indicators to meet the needs of the Branch. However, there is a process through Branch Management Team (BMT) that must be followed before indicators are changed or added. Managers have indicated that in order to add new indicators, they communicate through their administrator. BMT reviews the indicators annually through the planning processes.

The LTC Branch staff member producing these reports is the sole source of coordination and program management. Although all managers have access to SAP and other reports, the sole LTC Branch staff member is the only one able to provide the Balanced Scorecard metrics. The loss of such a staff member would result in a data production lag.

Some indicators are utilized within the Balanced Scorecard to measure work plan outcomes (e.g., desire to be home of choice - wait list, resident and family satisfaction surveys). However, the ultimate outcomes are not directly linked to the Balanced Scorecard.

Role of the Functional Teams in Business Planning.

The functional teams are becoming more active and meeting on a more regular basis. Some teams are more advanced than others but by and large the format is effective. The work of the functional teams is leading to an improved sharing of information. Improved communications within the functional teams is a result of active members. The strengths and expertise at each home are different and these forums provide an excellent mechanism to share the expertise and identify resources (internal/external) to improve services. This is further supplemented by the increased interaction with the Ontario Association of Non-Profit Homes & Services for Seniors (OAHNSS) Region 7. There is a desire to expand the functional teams to include a designated Food Service Supervisors team, as these managers currently do not participate in such a forum.

Recommendation 53

That the Branch continue to perform an indicator needs analysis on an annual basis based upon quality management activities to ensure relevance of Balanced Scorecard indices.

Management Response

Management agrees with this recommendation and it is current practice. An annual review process has been in place since LTC implemented the balanced scorecard approach in 2005. The branch will continue to perform an annual review of indicators as a part of this existing process that includes participation from all management levels in long term care. All managers have an opportunity to raise issues with indicators at their monthly functional team meetings, at quarterly LTC meetings and at the formal annual review of the balanced scorecard process. These submissions can be written or verbal. In the Q4 2009 review of terms of reference a documented requirement for a written submission of indicators will be considered.

Recommendation 54

That, as part of the implementation of Telestaff, the practice of generating staff models reports be established.

Management Response

Management agrees with this recommendation and confirms that it is part of the implementation plan. This is included in the phased implementation plan for Telestaff. Homes already implemented are currently receiving reports. Regular management reporting mechanisms will be fully established by Q3 2009.

Recommendation 55

That the Branch assess the risk of absence of the sole staff member responsible for the Balanced Scorecard indicators and respond with an appropriate contingency plan.

Management Response

Management disagrees with this recommendation. This function is not that of a sole staff member. All managers are responsible for entering their program data into the balanced scorecard templates and there is a manager with oversight responsibility for the program. To date there have been no issues with this approach, which is reviewed annually as part of strategic and operational planning process.

6.3.3 Performance Audit Objective 3

To assess the effectiveness of the model of Centres of Excellence services from a long term care perspective.

Audit Criteria

- Function specialists are available and knowledgeable of long term care requirements and uniqueness.

- Advice and information provided by COEs is relevant, reliable and timely.
- Real time access to key information metrics is available, understandable and utilized.

Observations

The Branch and its homes are supported by three key COEs, namely the FSU, RPAM and Employee Services, which also address health and safety.

Financial Support Unit (FSU)

There is a clear commitment from the FSU staff and they have a solid knowledge base of LTC operations. However, the knowledge rests with individuals rather than the unit as a whole. The FSU is located away from the homes. There is generally good communications between the homes and the FSU. However, there are some areas whereby staff are unaware of responsibilities and there seems to be a disconnect with respect to information flow, particularly regarding trust accounting and admissions.

The overall budgetary reports and information is timely and relevant. However, there is a lack of analysis and trends being provided to management in order to improve decision-making. As well, the concentration of most reports is on expenses and there is limited interaction between the homes and the FSU with respect to the revenues.

The resident and family satisfaction surveys indicate that the FSU provides a good level of service. However, the exploration of service satisfaction specific to financial matters and interactions with the FSU are limited in scope. Thus, an opportunity exists to more fully examine these services.

Real Property Asset Management (RPAM)

A full-time RPAM employee is designated to each of the City homes. While not formally a part of the senior management team of the homes, the RPAM employee plays a fundamental role within the home with responsibilities for capital asset planning and preventative maintenance. However, management in the homes are unaware of the overall long term capital plan for the buildings and equipment. With a minimum capital budget and lack of accountability for the buildings, home administrators are not in a position to ensure they are meeting their responsibilities to ensure a safe and healthy home for residents.

Human Resources and Health and Safety

Human Resource expertise, including health and safety advice, is provided by corporate City resources. The Employee Services Branch has provided key contacts for the LTC Branch which have been described as relatively accessible and responsive. Furthermore, the health and safety resources assist the Branch management in managing return to work and WSIB claims.

It was noted during the audit that although the health and safety corporate resources are responsive, they have not provided resources to revamp the LTC Branch's health and safety policies and procedures to date. Health and safety policies are general in nature and do not provide full guidance with respect to health care health and safety requirements under the regulations. This represents a risk for the City given that the Ministry of Labour (MOL) has recently identified an increased health care enforcement strategy. Should a MOL Inspector visit the City's homes, they will first and foremost review policies, procedures and activities of the Joint Health and Safety Committees. Without a complete set of policies, the City could face MOL orders for compliance.

Recommendation 56

That respective roles and responsibilities of the FSU, RPAM, Employee Services, Branch staff and home staff be documented within a service agreement with performance standards and expectations.

Management Response

Management agrees with this recommendation. Service level agreements currently exist, but will be updated to reflect specific roles and responsibilities, performance standards and expectations.

Human Resources will work with LTC to update their service level agreement by the end of Q2 2009. RPAM will begin work with LTC to develop a service level agreement in Q3 2009. With respect to the FSU, roles and responsibilities will be documented as organizational restructuring develops. This will be completed by Q1 2010.

6.3.4 Performance Audit Objective 4

To determine the degree to which the current Branch and home organizational structures promotes accountability.

Audit Criteria

- An accountability framework exists that clearly defines authorities, responsibilities and accountabilities for all levels.
- The performance management program integrates business plans and defines the goals and accountabilities of all management and staff.
- The reports produced by the Centres of Excellence and the Branch provides meaningful information and assist managers to meet their objectives.

Observations

Accountability Frameworks Across the Branch

Under the Homes for the Aged and Rest Homes Act (as well as the proposed Long Term Care Homes Act), City Council has ultimate responsibility for the long term care operations of its four homes. Council also has responsibilities for health and safety under the Occupational Health and Safety Act. Under the current structure and function of City governance, the CPS Committee is accountable for the aforementioned operations on behalf of the Council. The Director of the LTC Branch provides regular reports to the Chair of the Committee. This well-established practice is considered both appropriate and adequate according to the Director.

It is important to note that the regulations clearly indicate that the administrator of the home is directly responsible to City Council. The interaction of the Home Advisory Committee and the appointed City Councillor for the respective Ward does provide some interaction with Council.

Recommendation 57

That the orientation program provided for new City Councillors incorporate a segment that outlines their responsibilities under the LTC Act and the OHS Act.

Management Response

Management agrees with this recommendation. As part of the next new Councillor orientation program, LTC will review information provided and will ensure that materials are updated to reflect any changes with respect to the new *Long Term Care Homes Act* by Q3 2010. In addition, Occupational Health and Safety (OH&S) will incorporate an overview of the employer's responsibilities under the *OH&S Act*.

Performance Reviews

CIPP performance reviews are tied to incremental pay changes. Therefore, the staff follow up on reviews to ensure they are completed on time. The Mission, Vision, Values document (a requirement of Accreditation) is posted in each home, shared at time of hire but is not a part of a regular review cycle. Staff in CIPP have regularly completed performance reviews whereas not all CUPE staff performance reviews are completed on time. Inconsistent follow up and performance management could lead to employee dissatisfaction, reduced retention, morale and outdated skills. The staff that we met with had received a recent performance review and indicated that it had occurred by their direct supervisor.

Recommendation 58

That performance reviews be completed on a regular basis to assess training requirements and re-establish commitments and set goals for the upcoming years.

Management Response

Management agrees with this recommendation. Current practice is that annual performance reviews are completed for full-time CUPE 503 and CIPP staff and, every two years for part-time and casual CUPE 503 staff. A staff performance review database is maintained to ensure targets are met and managers are provided with a monthly report listing performance appraisals due for the month. Performance appraisals for supervisors and managers include an expectation for performance appraisal completion with staff and outcomes are monitored through this process. A pilot project was initiated at Armstrong Home in Q4 2008 to submit the training and development plan portion of all staff performance appraisals to the coordinator of training and development to facilitate an analysis of the types of issues identified in developmental plans. Pending the outcome of this pilot project, changes to the process will be introduced to all homes in Q1 2010.

Meaningful Reporting

The high level reports from FSU show results against budget at both the departmental level and the envelope funding level. Managers have been trained to access SAP for detailed financial information. Interviews indicated that managers feel they are accountable, as they are required to produce monthly variance reports to the Administrator and the Director.

While the City implemented SAP, it has not implemented an inventory management system. Without a bone fide system that controls departmental inventory, managers state that it is difficult to monitor appropriate purchasing levels and to identify inefficiencies. Similarly, without the benefit of staffing reports and their corresponding trends analysis, managers indicate that situations of understaffing and overstaffing occur routinely. These circumstances are interpreted as being of potential risk to the organization and its residents, especially in the case of the former. Staffing reports will also assist managers in analyzing the results against the service delivery model.

A specific example of the impact of a weak and/or non-existent inventory management system lies in the food service units. The LTC Branch has played a key role in developing a temporary solution for dietary to assist the food service supervisors with menu planning. Hospitality managers re-input food costs into spreadsheets to assess meal costs and attempt to keep raw food costs down.

Both FSU staff and Branch/home management expressed that there is a continuous improvement process in place relating to report development and generation.

Recommendation 59

That, following the implementation of Telestaff, the Branch and FSU work together to produce staffing reports to measure against effectiveness of the Service Delivery Model.

Management Response

Management agrees with this recommendation. LTC, Financial Services and Human Resources will develop reports to measure service delivery model effectiveness following implementation of Telestaff in Q3 2009.

6.3.5 Performance Audit Objective 5

To determine the effectiveness of quality management system in identifying quality initiatives and risk management.

Audit Criteria

- The quality management system is documented and understood by staff, residents and families.
- Service standards have been established based upon client expectations, are published and are updated on a regular basis.
- The service standards are measured and analyzed on a regular basis. Results are shared with internal and external stakeholders and serve to inform continuous improvement initiatives.
- A feedback system allowing for concerns of all stakeholders exists and is integrated into the quality management process.
- The quality management plan comprised of a calendar of quality activities and risk initiatives is developed and updated on a regular basis and results are analyzed and communicated.
- The results of various quality initiatives are incorporated into policies and procedures in a timely effective manner and revisions are made to the quality management plan in a timely fashion.

Observations

Documented Quality Management and Continuous Improvement Initiatives

The Branch's work plan represents a significant effort at ongoing improvement and growth for the LTC operations. The work plan has key messages which incorporate its mission, vision, values and its four pillars.

For the most part, there was evidence that quality management plans are in place by home and units. Some homes have more extensive quality management initiatives activities than others. It was observed, however, that the forms and methods of communication are inconsistent between units and across homes. For homes that do document, documents are kept on file so that homes are able to

measure their progress and discussions can occur at the identified committee meetings.

Recommendation 60

That quality management plans and initiatives be discussed regularly at the Branch level to establish their standardized requirements and to promote consistency amongst homes.

Management Response

Management agrees with this recommendation. Quality management plans have been reviewed quarterly at branch management team meetings and annually in concert with home managers since 2007. The quality management program is documented in policy and procedure 700:34 and was revised in Q1 2009 to reflect changes to the balanced scorecard program reporting process.

Concern Mechanisms

Policies are in place to support client feedback and timeframes. The homes have a method for logging concerns; however logs are not necessarily maintained for identified concerns as would be beneficial for the purposes of trending or developing new indicators. At Champlain and Garry J. Armstrong, concerns and complaints are provided to quality management committee.

Comprehensive Quality Management Program

There are homes that have comprehensive quality and risk management programs in place. Specifically, Champlain and Garry J. Armstrong are leading the way such that changes can be directly attributed back to the quality framework that they have established in their respective homes. Turnover in leadership and strengths in individual managers has had an impact on the extent of the quality and risk management programs. Standards for all homes by unit and audit tools will help build a platform for sound quality and risk management practices and provide opportunity for active sharing amongst all homes.

The quality management indicators are being used by the Program Managers of Resident Care[3] and some other functional teams to establish new policies consistent with best practices. Individual homes are piloting different programs for evaluation prior to roll out to other homes. Proactive utilization of Balanced Scorecard indicators provides an opportunity to actively review trends from the indicators, benchmark and establish action plans for improvement or recognition for a job well done.

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[3] One of the functional teams set up by the Branch to facilitate communication and joint planning/ development efforts between and amongst the four homes. Members of PMORC are responsible for the nursing and personal care department within their respective homes.

The current approach of performing pilots and adjusting based upon results of the pilots prior to Branch-wide implementation is a good practice that reduces an organization's risk.

Recommendation 61

That the Branch and its homes continue to utilize quality management indicators to inform their reviews of policy and practice and that a routine review of the indicators be undertaken to ensure that they remain relevant to the organization as measures that assist in the monitoring of care and service quality, and mitigate the potential for undue risk.

Management Response

Management agrees with this recommendation.

Quality indicators are reviewed quarterly and work plans are established annually, and as part of the of the three-year accreditation process. The quality management program is documented in policy and procedure 700:34 and was revised in Q1 2009 to reflect changes to the balanced scorecard program reporting process.

6.3.6 Performance Audit Objective 6

The degree to which the Branch adopts industry best practices.

Audit Criteria

- Managers and staff undertake research and development of best practices in other jurisdictions and communicates across the organization.
- Managers and registered staff are active in the overall seniors agenda and broader community.
- Professional standards are utilized to improve care for residents. Staff share professional information and advice with others to promote excellence of care.

Observations

Research and Development of Best Practices

There are appropriate policies to support research. Currently, Peter D. Clark Centre is the only home involved in a formal research project. This project is focused on the impact of living environment on persons living with dementia. The Branch has been involved in other research activities in the past and continues to foster relationships with the academic community through which new research opportunities may emerge.

There are many examples of best practices throughout the homes and across the units. There is also a genuine willingness and interest in sharing best practices across the Branch for adoption by others. The access to best practices is through a

number of recognized associations including OMBI, Registered Nurses Association of Ontario (RNAO), Ontario Association of Non-profit Homes and Services for Seniors (OAHNSS). These best practices are communicated through the functional teams. Some of the new managers have joined the City homes from other long term care providers and are utilizing their varied knowledge within the home and functional teams to improve services. Participation in vendor-sponsored activities also is routinely explored.

Informal communications with other local, not-for-profit long term care operators occurs regularly with an exchange of ideas and sharing of information to help support implementation of best practices.

Activity in Seniors Agenda and Broader Community

There is active membership in various associations and working groups by the homes. The homes are active participants in Region 7 OANHSS meetings and many spoke of linkages to other homes through this association as well as updates on provincial announcements/directions in long term care. The opportunity for cross-jurisdictional participation is hindered by budget constraints; this could lead to a reduction in participation and hence less informed professionals.

All of the homes' representatives were able to speak to some level of community and/or professional involvement amongst members of the senior management team in the local area, for example, the positions on the Aging in Place Committee, Seniors' Impact Council, Ottawa Hospital committees, RGP councils/committees, Gerontological Nurses Association, etc.

Professional Standards to Promote Excellence of Care

A policy exists to direct the training of staff and when they can access training and development. There are, however, limited funds for upgrading staff competencies. Free initiatives through MOHLTC, suppliers and associations are utilized. Program requirements are increasing without dollars attached. This is being experienced by all long term care providers. Funding to support staff training is required so that staff are able to deal with the complexities of the resident population in LTC homes and the increased demands by families, residents and regulators. The Branch needs to continue its efforts to impress upon the City that the knowledge and professionalism of staff is key to fulfilling its mission.

The Learning and Growth Committee establishes and monitors the LTC work plan, however, there are no funds to replace staff on training. These funding pressures have a direct impact on the level of training. Lack of training may result in reduced service delivery, increased client concerns and decline in resident care.

Recommendation 62

That the Branch continue to explore cost effective methods to gain access to industry best practices with planned implementation of these practices throughout the organization.

Management Response

Management agrees with this recommendation. LTC undergoes an annual efficiency review and participates in OMBI. A recent realignment of the supervisor of Resident Care position in each home to the coordinator of Best Practice will allow a broader sector and interdisciplinary approach to these annual reviews and will include such components as provincial and national associations, content experts, conference proceedings, literature reviews and peer reviewed journals.

Recommendation 63

That the Branch continue their current active involvement and encourage others to become involved in local seniors' and long term care issues so that the City's LTC visibility is promoted.

Management Response

Management agrees with this recommendation and this is current practice. For the past four decades, LTC has led senior's initiatives and participated in long term care sector partnerships and community partnerships, such as Successful Aging Ottawa, the United Way/Centraide Seniors Impact Council, the Senior's Agenda, the Champlain Dementia Network and the Regional Geriatric Advisory Committee to improve the role of LTC and promote research and best practice in City LTC homes. This leadership role has traditionally been the responsibility of the Director LTC and will be continued wherever possible within current staffing and management levels.

Recommendation 64

That the Branch review training requirements in light of mandatory requirements as well as professional practice.

Management Response

Management agrees with this recommendation and the current practice will be formally documented as a policy to ensure consistency. Mandatory training is reviewed annually to ensure it is up-to-date with current practice. Professional training is reviewed annually to ensure regulatory requirements are met.

6.3.7 Performance Audit Objective 7

To evaluate resource utilization in the context of legislative requirements, efficiency and effectiveness.

Audit Criteria

- Resource utilization monitoring mechanisms are in place to assess compliance with budgetary and operational plans. Timely processes for corrective actions are in place.
- Management reports incorporate financial and non-financial performance information which informs short and long term decisions.
- The allocation of staff and location serve the needs of the residents and meet legislative requirements in order to meet the goals and mission of the organization (right staff, right time, right place).
- Services are provided and managed based on the premise on the best value for money with the view to serve as a benchmark for other homes. Managers constantly review costs against results to assess economy, efficiency and effectiveness
- Managers review competitive purchasing opportunities and identify economies of scale through co-operative purchasing
- Technological solutions to maximize staff utilization and value added services are in place and/or explored as means for achieving efficiencies.
- Resident-centred approach is taken with respect to business processes and reengineering. Technology and business processes are geared to promoting maximum resident care time and reducing administrative tasks for care staff.
- Training and staff development plans are completed annually. Training is relevant and reflects full scope of practice. A knowledge management plan exists to capture employee skills and knowledge.

Observations

Human Resource Utilization Associated with Resident Care

Based on the information reviewed, there is adequate staffing in each of the homes and within units across the 24/7 operations. In particular, there was no evidence to the contrary in the compliance reviews or family concern logs. There were however, significant concerns across the organization related to the gapping requirement. The evidence suggests that there may be a need to determine consistent staffing levels rather than non-replacement policies which are variable across the homes.

The Service Delivery Model guides the budget process and replacement approach. Currently, there is limited ability to measure staffing ratios and Service Delivery Model effectiveness. This issue will be addressed in part with the recent initiation of the Telestaff scheduling system implementation process.

The role and responsibilities of the social worker position varies between the homes. As a consequence, there is the potential for different levels of service to residents across the four homes. Only in certain homes was there evidence that the

social worker completes an extensive assessment for each resident on admission. The position's responsibility for all aspects of the admission process may warrant further review from a cost effectiveness perspective. There may be potential for redistributing the clerical work associated with the admission process to another position within the respective homes to better utilize the skill sets of the social workers, especially given the high proportion of whom are master's prepared professionals.

It was observed that the impact of a protracted absence of one social worker, whose position was not replaced, resulted in some significant backlog in resident documentation as the workload was not fully redistributed amongst other members of the management team and/or social workers across the other homes.

Recommendation 65

That the Branch review the requisite skills and roles of the social worker position to determine the best use of this staff position from the joint perspectives of its contribution to the interdisciplinary care to residents and cost effectiveness.

Management Response

Management agrees with this recommendation. This position is presently under review to identify the elements of the position that are administrative and the elements of the position that draw on social work expertise. Job evaluation results are expected to be complete by Q1 2010.

Supply and Labour Cost Management/Containment

It was evident that the Managers have established a standard practice of reviewing their unit's costs for staffing, supplies, etc. on a regular basis. As such, the access afforded senior management to SAP is well utilized.

The food cost per meal day figures suggest that further review is warranted. It is understood that part of the discrepancy between the homes can be explained by the food service contract at Champlain.

It is understood that as of fairly recently, more cooperative purchasing has been undertaken. A newly implemented agreement with Complete Purchasing is generating positive results.

There was no evidence of an inventory system and the corollary of this is that managers were not able to provide details on the qualities and costs of supplies. There is the risk that without the benefit of a system that monitors inventory and spending on supplies, managers will not be equipped to observe increases in costs or other important trends. Furthermore, without the inventory system there is lesser potential that managers will be able to stay abreast of trends or identify opportunities for cost efficiencies and greater effectiveness in departmental operations. Inventory management issues are discussed more fully later in this report.

Recommendation 66

That more cooperative purchasing be pursued across all homes.

Management Response

Management agrees with this recommendation. LTC implemented a cooperative purchasing process in 2007 through a consolidation of the request for tender process across the homes. Purchasing for medical supplies, food and environmental services is coordinated through standing offers.

Project Management Resources

For new projects and contracts, central purchasing assists in developing RFPs and Tenders on behalf of the Branch. At present, there are two major initiatives in implementation that directly involve the Branch, namely the Telestaff scheduling system and the Goldcare Resident Care Documentation System. Both projects represent add-on modules to the existing systems in operation at the Branch and City. For example, Goldcare has been used for billing and trusts, whereby the Telestaff system has been in use by the EMS Branch. It is recognized that these two key technology implementations are still in their infancy. However, early results show that technology is being embraced by various levels and the benefits of these initiatives over their previously used manual counterparts are well recognized.

Despite the fact that these two implementation processes have begun, there was no evidence of detailed project plans, which identified key milestone dates, training plans, responsibilities or deliverables. This lack of project planning and project management activities and tools may place these projects at risk of a successful and timely implementation.

Recommendation 67

That project plans for the Goldcare and Telestaff projects be developed to include successes to date, milestones, training and deliverables with a view to facilitating timely implementation processes.

Management Response

Management agrees with this recommendation. Project plans for the Goldcare and Telestaff projects were developed by long term care to secure initial project funding and support from IT services. Telestaff has a multi-phase implementation plan, which will be completed by Q3 2009. A steering committee has been established to identify strategic opportunities and areas for policy development with regard to the ongoing use of the Goldcare system. In addition, a Goldcare user group has been established to support staff in the resolution of ongoing user issues and to identify additional user requirements related to annual software upgrades.

Recommendation 68

That upon implementation of the Telestaff system, the Branch and FSU work together to develop a regular schedule of reports and variance analyses that will assist managers in determining appropriate staffing levels.

Management Response

Management agrees with this recommendation. LTC, Financial Services and Human Resources will develop reports to measure service delivery model effectiveness following implementation of Telestaff in Q3 2009.

6.3.8 Performance Audit Objective 8

To assess the level of service and satisfaction of residents, families and taxpayers with the four long term care homes.

Audit Criteria

- Satisfaction surveys are undertaken on a regular basis and the results are published and utilized to assess services. Surveys questions are reviewed for relevance.
- Satisfaction surveys assess different types of services including food, laundry, hairdressing, etc.

Observations

Measures of Stakeholder Satisfaction

The homes have a well-established methodology for monitoring the satisfaction of its key clients, namely residents, families and staff. The survey tools are based on the OMBI template to allow for comparison of results and benchmarking. There is an annual cycle for disseminating the satisfaction surveys to the various stakeholder groups. The response rates are adequate and consistent with industry results. The homes share results with the respective stakeholder groups and further analyze the results within departmental and functional team meetings.

On a consistent basis, the satisfaction surveys show positive results with well over 90% of the respondents expressing satisfaction with the care and services provided by the homes. These rates indicate that the homes for the most part are meeting the needs and expectations of residents, families and staff.

Peter D. Clark Centre represents a recent anomaly in the satisfaction results in that there has been a decline in its rates over the last three years. It is understood that management of the home is working diligently to better understand the underlying causes of this trend.

There was some suggestion that certain units were interested in enhancing the survey to better elicit questions of particular relevance to them. These ideas have been taken to the various functional teams for further consideration.

Community Awareness and Support of City Homes

Each of the homes enjoys a strong reputation in the community as is in part reflected in the length of their respective wait lists. Each home also benefits from a direct relationship with a designated City Councillor. While the level of involvement of these Councillors varies between the homes, this relationship has, in many instances been beneficial in raising awareness of the homes and their quality long term care services.

Recommendation 69

That the various survey tools be reviewed on a regular basis to ensure the questions are generating meaningful, useful information and to determine the relevance of the content for service improvement purposes across all operational domains.

Management Response

Management agrees with this recommendation. Survey tools, such as the resident satisfaction survey, the staff needs assessment survey, the palliative care survey, the admission survey, etc. are reviewed on an annual basis before they are re-implemented. As an example, in 2008 the resident satisfaction survey was modified to allow more detailed information in specific service areas to allow managers to capture specific program data to facilitate modification of their program offerings.

6.3.9 Performance Audit Objective 9

To assess the readiness and understanding of the Branch to move to full accrual accounting as required by the PSAB in 2009.

Audit Criteria

- The Branch and its staff have been trained in the new requirements and understand their role in the changes

Observations

As mentioned earlier, by January 2009, all Canadian municipalities must move to full accrual based accounting in order to comply with the accounting standards set by the PSAB, the standard setter for the public sector in Canada. PSAB has adopted these new standards which require significant changes to the municipal financial statements with the inclusion of all non-financial assets. The most significant change is the requirement to capitalize tangible capital assets (TCAs) and amortize the historical cost over the useful life of the asset. In other words, the cost of TCAs is expensed over their useful lives and the historical cost of their utilization is recognized accordingly. These new standards are outlined in PS3150 and new reporting standards are outlined in PS1000-1200. There was no evidence that

management understood the vast changes required in financial reporting, nor was there a sense the staff were involved it this large-scale initiative of change.

Recommendation 70

That the Branch and FSU engage in discussions with the PSAB lead at the City to assess the impact on LTC reporting in a full accrual accounting environment.

Management Response

Management agrees with this recommendation. Discussions have already taken place and will continue into the future to ensure that PSAB 3150 requirements are met prior to the 2009 reporting of financial statements by mid 2010.

6.3.10 Performance Audit Objective 10

To evaluate the degree to which assets are safeguarded and managed.

Audit Criteria

- Asset management plan is in place including condition assessments, life cycle, replacement plans and costs.
- Inventory management system is in place and operating effectively.

Observations

Asset Management Plans

Asset management is viewed as an RPAM role and conducted by RPAM with some consultation with the homes. However, there is no life cycle costing system to determine the costs of equipment and determination of replacement. Some homes are relatively new and therefore, new equipment was purchased upon construction. For example, PDC and Garry J. Armstrong were built seven and four years ago respectively whereas Champlain and Carleton Lodge have been redeveloped. Consequently, equipment will approach the end of their useful lives in the next three to five years and the impact could be significant. Currently, the Branch has limited capital budgets (approximately $350,000 annually) and trade offs are made to meet that budget. Management has not generally been involved in assessing the condition or effectiveness of equipment and is unaware if a long term asset management strategy has been developed for their facilities.

Recommendation 71

That the Branch, in consultation with RPAM, develop a long-range asset management plan that encompasses a replacement plan over a minimum 20-year horizon for all buildings and equipment.

Management Response

Management agrees with this recommendation. As the corporate landlord, RPAM has conducted the necessary condition reviews on Carleton Lodge, Centre d'Accueil Champlain and Peter D. Clark Home in order to establish a long-range capital lifecycle renewal plan and comprehensive asset management plan for the City's long term care facilities. The results of these condition reviews have been factored into the overall lifecycle renewal plan over the next 20 years with a significant investment already being made, most notably, at Carleton Lodge. As it is a newer facility, a condition review of the Garry J. Armstrong Home will take place in five years time and the result will be incorporated into the overall lifecycle renewal program.

Inventory Management

As discussed, there are currently no inventory management systems in place in the LTC Branch. However, there is a desire of the majority of management to implement a system. Currently, the stores person performs the majority of purchasing through telephone orders following requests from program managers and nurses on the night shift. These requests are called in to the supplier. They are neither documented procedures nor inventory management systems in place to ensure that a level of supplies is appropriate. Receiving of goods is undertaken by the stores person as well. However, no documentation is provided to back up the order or the receiving procedures. No year-end physical count is undertaken for accrual accounting purposes, nor are there regular counts of supplies. There is currently no mechanism to manage stock and distribute stock. The stores person expressed that he did not have access to a computer.

For managers to assess their efficiency, they have had to recreate financial data in their own systems (such as spreadsheets) in order to manage their inventories. This is particularly true in hospitality services whereby inventories of raw food is critical.

The City has not implemented the inventory management module of SAP within the LTC Branch. The impact is the potential for inappropriate use of City funds and supplies. During the course of the audit, Corporate Security informed the Auditor General of an incident at one home involving the theft of small amount of a controlled medication. The lack of proper inventory controls was a contributing factor in this case.

As previously mentioned, these issues at the City of Ottawa are discussed more fully in the 2007 Audit of Inventory and Asset Management Processes. In that audit, management indicated that it was the responsibility of each operating area to develop inventory management policies and procedures. The audit opinion was that this City-wide responsibility should rest with the Financial Services Branch.

Recommendation 72

That the Branch implement an inventory management system, including food management and medical supplies inventory.

Management Response

Management agrees with this recommendation.

The City is committed to protecting the assets of the corporation. Operational directors within the corporation are accountable for the control and safeguard of City assets they use in the delivery of services and are in the best position to align appropriate controls with their operational requirements. This is clearly stated under 'Management Responsibilities' within the City's Code of Conduct where it states: "The management of the City is accountable for protecting the assets of, and the public trust in, the City. Towards this end, management must make every effort to establish and maintain adequate systems, procedures and controls to prevent and detect fraud, theft, and breach of trust, conflict of interest, bias and any other form of wrongdoing."

There are corporate policies in place covering the capitalization, depreciation, identification, accounting, recording and safeguarding of City assets and inventory and these are clearly outlined in the responsibilities within the corporation. The food, medical supplies or other consumable materials used by the LTC Branch are items expensed during the year and are not within a major asset class and do not go into a stores inventory system. The significant majority of these supplies and materials are purchased on a "just in time basis", are expensed and immediately consumed or used. Those items relate to purchases made in the delivery of LTC services and are not appropriate items for inclusion in inventory.

Notwithstanding, LTC in conjunction with Financial Services will review the current systems and will implement, where necessary, an inventory management system, additional controls or mitigating measures to limit risk. Funding requirements will be identified in the 2010 budget. This will be implemented by Q3 2010.

6.3.11 Performance Audit Objective 11

To assess the effectiveness of the human capital and investment plan.

Audit Criteria

- Succession and retention strategies have been developed and implemented.
- Staff consultations are established in order to gain feedback on growth and learning strategies as well as address ongoing human resource issues.

- Performance planning processes are undertaken and up to date. Plans serve to inform training plans and programs.
- A comprehensive learning and training plan reflects both mandatory and growth opportunities. Training is included in individual, team, section and departmental plans.

Observations

Succession and Retention Strategies

There is evidence of sound succession planning within the Branch particularly within the Branch Leadership Team.

Comprehensive Learning and Training Plan

General orientation has recently been standardized across the homes and the Orientation Guide is complete. There has also been significant effort to establish a Branch-wide annual training framework. From this framework, each home has developed a specific learning and training plan for the current year that lays out a schedule of in-service training sessions. According to the education coordinators, the plans encapsulate four mandatory sessions and six topics derived from the various information and risk assessment sources per month. The coordinators have been engaged in generating Branch-wide staff development policies and completing the staff learning survey.

To date, there are no formal training profiles developed for each training session that ensures continuity and consistency in material delivered to staff across the Branch. These profiles should include learning objectives, key content points, evaluation and feedback methods (evidence demonstrating retention of new skill/knowledge and ability to apply in practice), training materials used, and additional resources. Some materials are shared between homes and supplier/association resources are well utilized thus accounting for some consistency. Champlain is somewhat disadvantaged in that much of the training reference materials used in three of the homes are not available in French.

Staff attendance records are maintained for each session delivered. Of particular note is the attendance target set for staff in each home; the 70% target is significantly less than the 100% used in the industry and expected by the MOHLTC. Evaluations of each session are undertaken although it is difficult to ascertain the value or success of the session on the basis of the evaluation form as formal learning objectives for the sessions have not been established.

Some of the coordinators were not aware of the mandatory requirements of the MOHLTC related to annual training or recognize the incongruence of Branch policies with MOHLTC expectations (e.g., resident rights, resident abuse, care for persons with cognitive impairment/disruptive behaviours, infection control, fire

training and life safety plans, CPR, hot weather related illnesses, back care, WHMIS).

Staff Input Into Growth and Learning Strategies

Staff across all units in the four homes have some input into the development of the annual training plan that is shared by the homes. Staff were asked to respond to a learning needs survey. The results of this survey were used in part to establish the current year's annual training plan. Managers were also asked to speak with the staff of their units and to provide a list of skills and knowledge-based training requirements. Managers use annual performance reviews as a source of ongoing staff development ideas and concerns. These are brought forward informally to the education coordinators as there was no evidence of a formal interface between planning activities associated with staff development and annual performance reviews. It is common in the LTC industry to have a documented feedback loop between these two related events.

Staff Investment Strategy

The Staff Investment Strategy is well represented in the various home-specific work plans, but no formal project management document was available to better understand the approaches, participants, goals/objectives, measurable outcomes, timeline, leadership responsibilities, or resource requirements. Therefore, there was no evidence to connect the annual training plans to the overreaching objectives and directions of the Strategy. There was considerable discussion on the lack of adequate funds to support the staff development program which is somewhat inconsistent with the Branch commitment to enhancing the skills and knowledge of its LTC workforce.

Recommendation 73

That the Branch and its education coordinators revisit the attendance target for in-service training and explore the best practices that have been developed by other homes to facilitate the comprehensive, cost effective strategies for delivering the MOHLTC mandatory training sessions to all staff on an annual basis.

Management Response

Management agrees with this recommendation and a review is underway. In an effort to continuously improve delivery and effectiveness of mandatory training programs, management is presently reviewing the delivery model. A recommendation regarding possible changes will be brought to branch management team in Q2 2009.

Recommendation 74

That the Branch develop a comprehensive staff development trainers' manual with comprehensive training profiles for each in-service topic.

Management Response

Management agrees with this recommendation and it is being implemented. LTC will consolidate existing training programs, develop a comprehensive manual which includes all items covered in general staff orientation, and will post it on Ozone by Q4 2008.

Recommendation 75

That the Branch develop a Staff Investment Strategy Framework to guide the home-specific training efforts and to align scarce resources for staff development effectively.

Management Response

Management agrees with this recommendation. The Learning and Growth Committee identifies training needs through the annual staff needs assessment. The Learning and Growth team submits an annual training plan for approval to the branch management team. The priority for funded staff attendance at training is established based on needs identified in this annual plan.

7 JULY 2001 LTC ALTERNATE SERVICE DELIVERY REVIEW

7.1 Overview

An assessment of potential alternate service delivery options for LTC was not included in the audit plan for this audit. However, in 2001, management requested that the former Audit and Consulting Services Branch undertake an analysis of possible long term care service delivery models to ensure the City is maximizing potential savings and making the most effective use of tax dollars. It was felt it would be useful to provide a summary of this 2001 study to management and Council as part of this audit report for consideration.

It should be noted that this 2001 review did not result in an exhaustive analysis of each option presented. Rather the analysis and recommendations were intended to assist management and Council in determining which alternative service delivery (ASD) model, if any, it wishes to pursue fully. The following is a brief summary of the analysis completed in 2001. A detailed report was prepared at that time and provided to management. The full report remains available from the Auditor General’ s office.

Analysis of ASD Options

The analysis was based on two factors: (1) options available to the City; and, (2) the eleven evaluation criteria outlined below. Aside from maintaining LTC as an internal City function, three alternative service delivery options were examined including:

1. Divestment to the private sector
2. Private-Sector Management Contract
3. Devolution to a non-profit corporation

The Assessment Criteria[4]

Key issues such as legislative requirements, existing contractual obligations and quality of care commitments should be carefully considered in assessing each ASD scenario. Each criterion used in this analysis is discussed below.

Assessment Criteria

Criteria	**Description**
Eliminate Municipal Subsidy	• The primary objective of ASD is to reduce and eventually eliminate the City subsidy. • Moving towards divestment could lead to savings but adds risk of decreased service.
Service Levels	• Minimum provincial standards must be met. • Ensuring adequate services to high-needs residents is a key consideration. • It is unrealistic to expect improved service levels at reduced costs.
Access to Expertise	• Moving towards divestment may provide access to experience and economies of scale.
Risk Sharing	• Partnering involves sharing operating and/or financial risks. As we move toward divestment, risk sharing becomes inevitable. • Residual municipal liabilities are dependent upon the specifics of the model.
Sale Proceeds	• Assuming partial or complete divestment, revenue is generated from sale. • The Ministry of Health and Long Term Care has a 50% financial stake in physical assets and would likely require a financial settlement in view of the provincial contributions over the years. • Satisfying the termination clause of the Service Level Agreement (SLA) with the Ministry, specifically dealing with the potential reimbursement of capital grants for the purchase of equipment and proceeds of sale.

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[4] Resources consulted in this analysis, included; **ASD Guidelines**, former *City of Ottawa*, Basics of Alternative Service Delivery, February 1998, **Guide to Preparing a Business Case for ASD**, *Province of Ontario,* **Shaping The Future for Municipal Homes for the Aged, A Guide for Municipal Administrators and Councils**, *Ontario Association of Non-Profit Homes and Services for Seniors,* and **Framework for Alternative Program Delivery**, *Treasury Board Secretariat, Government of Canada.*

Criteria	**Description**
Property Tax Implications	• Each service delivery model implies unique property tax considerations. • If facilities were sold, annual property tax revenue would be generated from the new ownership, revenue that would be directed to the City. • Should facilities remain municipal, current exemptions continue.
Legislative and Legal Implications	• City has an obligation to satisfy legislative and regulatory requirements. • Under current provisions of the Homes for the Aged and Rest Homes Act, Section 3(1) "Except as otherwise provided in subsection (2) or in section 7, every municipality not in a territorial district shall establish and maintain a home for the aged". • There is speculation the provincial government may revise the Act removing the requirement of municipality to maintain one long term care centre. • City must fulfill existing contractual obligations to residents and the Ministry.
Labour Relations/Human Resource Implications	• Movement along the continuum towards divestment presents challenges with regard to human resource and labour relations issues, specifically in fulfilling and honouring existing collective agreement commitments. • The Branch has staff belonging to CUPE 503, 2187, CIPP, ONA[5] and MPE associations[6]. Issues to address include number of staff affected and how; severance costs and successor rights; loss of skills and corporate memory; redeployment requirements and commitments; and, potential and ease of transfer of OMERS contributions.

Political and Public Interest Considerations	• Council currently is in a position to ensure the provision of adequate and appropriate services. Movement toward divestment changes this control framework, altering the level of influence Council can exercise over these services. Such changes must be consistent with Council's desires.
	• Public perception and potential loss of public confidence may occur as movement toward divestment occurs.
	    o Residents and families may face continuity and quality of care uncertainty.
	    o Existing French-language services as established at Champlain, and the other City facilities, must be maintained.
	    o The degree to which the future long term care needs of the community can be influenced may be compromised as we step closer to divestment.

[5] The ONA nurses union association has merged with CIPP. City salary administration is still operating from ONA pay scales and members are paying dues to ONA until negotiations take place.
[6] On-going union issues related to the amalgamation will influence the ultimate bargaining unit profile for LTC.

Criteria	**Description**
Ongoing Accountability Considerations	• Accountability issues become a factor as movement towards divestment occurs. • Partnering may result in relinquishing or sharing control for performance monitoring and reporting as well as in the determination of the types of services offered, service levels, and the pricing of services which may lead to struggle for accountability, as priorities may be different for each party.
Financial Implications	• Each option involves distinct financial implications, existing long term debt commitments, establishing fair market value for the homes, the provincial capital funding mechanism, costs associated with changing the model, market-related risks and the potential annual savings from the re-development of Island Lodge

The alternative service delivery options presented below seek to assist management and Council to make a decision on the future delivery of long term care at the City. Each option presents unique opportunities and risks. Clearly, the single biggest factor affecting each option is the human resources and labour relations impact associated with suggested changes in service delivery. As the majority of staff are unionized, the City is bound by the respective collective agreements, the Ontario Labour Relations Act and the Employment Standards Act all of which have specific implications for ASD.

Option 1: Divestment to the private sector

In this option, the City lists for sale; a combination of one to four of the long term care facilities through the RFP process with the intention to completely dissolve its involvement as well as its funding for operating, overhead and capital expenditures in the long term care business. Of course, this option's success is dependant on finding an acceptable purchaser via the RFP process. The organization successful in the purchase bid would be fully responsible and accountable for the governance of the facilities and community programs. The City would have no further responsibilities for the operation of these facilities.

Current provincial legislation states the City must ***"establish and maintain"*** one long term care facility. Therefore, the City cannot completely divest itself of its LTC program without provincial agreement or until the Province changes the legislation. The City could divest itself of only three out of four homes at this time unless otherwise approved by the Province.

To be successful, implementation of this option presents many important legislative, labour relations, human resources and financial issues requiring sensitive negotiations with unions, the Province and purchaser. Divestment may be viable in the long term but is only partially achievable in the short term.

Option 2: Private-Sector Management Contract

In this scenario, a contractual agreement with a private-sector partner is negotiated to take over the entire operation of one or more City facilities (and community programs) providing on-site management at each facility. Contracted management maintains Council's role in governance of the homes and care of residents, although agents have been hired to carry out the responsibility. Under this scenario, all risk associated with the operation of these facilities remains with the City.

Most importantly, contracting out is limited by the collective agreements of the City. Pursuing a private-sector management contract may present unique savings opportunities to the City. All management exempt positions and union positions that allow contracting out can be considered here. However, the CUPE 503 collective agreement does not allow management to contract out union positions if doing so creates job loss for members.

This option presents the possibility of less political and public influence on operations as well as financial implications of invoking the workforce adjustment policy. There are, however, several examples of both management and service specific contracting out that clearly indicate this is a feasible and attainable option. As well, should the provincial legislation change eliminating the City's requirement to establish and maintain a long term care facility, this option presents a unique opportunity to set the stage for divestment.

Option 3: Devolution to a non-profit corporation

In this scenario, one to four newly created non-profit corporation(s) would be responsible and accountable for the governance of the homes and community programs at arms length to the City. As a non-profit organization, all revenues would continue to be used for the provision of care and service for the residents of the homes and citizens in the community, as opposed to being directed to corporate profit. Historically, municipal operations have never covered their operating costs without some level of municipal subsidy. It's reasonable to assume the City subsidy would have to continue for a period of time to allow the non-profit organization time to organize the business and related functions. It is also possible the non-profit corporation could approach the City for additional funding or emergency assistance.

A number of different governance scenarios are possible under this option depending on City Council's desired level of involvement and influence. A board of directors would be established to govern any new not-for-profit operation, most likely made up of local citizens and potentially members of City Council. Should each home be set-up independently, it is possible four boards would be established, which would widen the agenda for each home and make operations less congruent. Management would report directly to the board.

Employee transfer issues remain although it may be easier to address by suggesting the union affiliations remain. Pension transfer issues exist for interested parties not participating in OMERS setting the stage for a period of lengthy negotiations.

Clearly, devolution to a non-profit entity presents an interesting option to management. There is a question of support and interest in the non-profit community to develop such an alliance; an answer can only be found with the development and issuance of an RFP. As well, non-profit divestment presents a less severe option in terms of political and public implications as the City's influence could be maintained through board membership.

Summary of ASD Options

The following table summarizes these three ASD options against the criteria outlined earlier.

Criteria	***Option 1*, Divestment to the Private Sector**	***Option 2*, Private Sector Management Contract**	***Option 3*, Devolution to a Non-Profit Corporation**
Elimination of the City Operating Subsidy	Achievable.	No guarantee but negotiable as part of the management contract.	No guarantee but negotiable as part of contract with the non-profit organization.
Service Levels	At risk, but must be maintained at provincial minimum standards.	At risk, but must be maintained at provincial minimum standards.	At risk, but must be maintained at provincial minimum standards.
Access to Expertise	Full access to industry specific expertise.	Full access to industry specific expertise.	Retained from existing City operations.
Risk Sharing	All risks transferred to the purchaser.	City maintains risk.	Assumed by non-profit organization.
Sale Proceeds	Potential, Province likely to seek a financial settlement.	No.	No.
Property Tax Implications	Potential property tax generation from sale.	No.	No.
Legislative and Legal Requirements	Municipality must establish and maintain one long term care facility. Signed resident agreements must be honoured.	Provided the contract outlines all provincial regulatory requirements, no implications.	Provided the contract outlines all provincial regulatory requirements, no implications.
Labour Relations/Human Resource Implications	Successor rights and potential issues with pay scales.	Management job loss for management contract. Partial outsourcing implicates CUPE 503 positions, which presents various labour	New non-profit organization must employ City employees, maybe issues with pay scales.

Criteria	*Option 1*, Divestment to the Private Sector	*Option 2*, Private Sector Management Contract	*Option 3*, Devolution to a Non-Profit Corporation
		relations implications.	
Political/Public Interest Considerations	Removes governance, which must be accepted by politicians and public.	Maintains governance but places day-to-day business in the hands of management contract.	Level of governance and influence may change depending on the set-up of the Board of Directors.
Ongoing Accountability Considerations	Rests with the purchaser.	Contract management reports directly to the MOH.	Rests with the non-profit organization.
Financial Implications	Problematic to establish fair market value. Province may require municipal contribution for a pre-determined number of years.	Cost to administer and monitor the management contract.	City most likely continues to pay for existing and new capital debt.
Examples:	None to date.	Region of Muskoka (management contract with private sector) City of Toronto (partial outsourcing).	CCAC.

Given the analysis presented here, in particular the current legislative and collective agreement constraints, complete divestment of the City's long term care program is not a realistic option for the short-term. Council and Senior Management may wish to give more serious consideration to the other options, specifically, private-sector management contract, devolution to a not-for-profit organization or maintaining LTC as a direct City service.

If, after considering the results of this preliminary analysis, there is interest in pursuing options 1, 2 or 3 further, the following next steps are recommended.

- *Completion of **stakeholder analysis**, including public and political consultations.*
- *Preparation and release of a comprehensive **RFI/RFP** if delivery method involves private sector or not-for-profit organizations.*
- *Verifying the full **financial impact** of each option involving comprehensive and comparable information, including all indirect and direct financial costs, revenues and benefits where they are identifiable and measurable. To be comparable, one must correct for different time patterns in the cash flows and different values for money over time.*
- *Decision and **selection of a delivery method**.*
- *Selection of an acceptable **supplier** as required.*
- ***Implementation** including contract design and management as required.*

- *Post-implementation* ***evaluation.***

8 CONCLUSION

The LTC Branch and its four homes provide quality resident-centred care and services. Furthermore, the homes have put into practice the Resident Bill of Rights, they reflect adherence to the MOHLTC compliance standards and consistently follow, for the most part, the Branch policies. Although the homes, on occasion, were found to have unmet standards, the compliance issues were addressed in a timely and appropriate manner with the exception of mandatory in-service training sessions on an annual basis for 100% of staff and Food Service Worker Certification. There are examples of innovation and creative program development within the Branch and at specific homes. These advances and successes in care and service practices routinely shared across the organization for implementation as new best practices. There remain, however, notable differences between homes despite significant, ongoing standardization efforts.

With respect to the trust and accommodation accounting performed by the FSU, there are significant deficiencies in records management. Although there have been few complaints, the lack of policies and written procedures as well as documentary evidence poses risks for the City. These practices need to be reviewed in light of the MOHLTC program standards and the Trust Act. The practices should be revised to ensure proper and thorough documentation is present in all resident files. A new satisfaction survey should be developed to measure the success of these initiatives.

The Branch should review its financial management and accountability framework. There is an inherent lack of inventory/asset controls as well as limited oversight and long term vision in this area. There is lack of adequate reporting mechanisms available to the management to ensure proper prudence and probity over public funds. Budgetary processes have not embraced modern comptrollership practices and tend to be developed from a top down approach rather than involvement from various levels of management. Furthermore, budgets are developed based upon affordability rather than need and do not reflect life cycle costs or capital plans over the long term.

9 ACKNOWLEDGEMENT

We wish to express appreciation to the staff and management of the LTC Branch; direct care and service staff and management of the LTC homes; and staff of the COEs, for their cooperation and assistance throughout the audit process.

Appendix A - CASE MIX MEASURE AND CASE MIX INDEX

The MOHLTC provides funding to long term care homes in envelopes, namely nursing and personal care (NPC), program and support services (PSS), other accommodation (OC) and raw food (RF). NPC, PSS and RF are referred to as flow-through envelopes, meaning that all the funds provided by MOHLTC must be spent as per the standards or returned to the ministry at the end of the year. The per diem funding for PSS, OC and RF is set by MOHLTC and is the same for all homes (per diem amount ($) x number of residents). The funded provided to the NPC envelope, however, varies on an annual basis depending on the level of care of residents in each home. The amount of funding for this envelope is determined by the LTC home's CMI (case mix index). The CMI is a measure used to express the level of care requirements of each LTC home and determines how funds for nursing and personal care are allocated across all homes in the Province. The CMI for an average LTC home is 100.

In the early 1990's the Province adopted the Alberta Resident Classification system as the basis for funding allocations for nursing and personal care in LTC homes. The Alberta Classification system consists of seven categories: A-to-G; with A representing the lightest requirement for care and service and G representing the requirement for complete and total care for all aspects of daily living. The mandate of LTC homes in Ontario is to provide accommodation, care and service to persons who are deemed to be in categories D through G, although many municipal homes for the aged continue to have long-stay residents who moved in under the previous legislative definition of eligibility.

The CMM is a measure of the levels of care required for the resident population in a home. This is calculated by determining the number of residents of the facility who were classified into each of the seven categories during the classification process in the previous year; dividing the number of residents in each category by the total number of residents of the home who were classified during the classification process in the previous year; multiplying the quotient obtained for each category by the weighting factor for the category; and adding the products. The Case Mix Index is calculated from the Case Mix Measure and converts that scale into a scale which has an average equal to 100. The Case Mix Index for a LTC home is determined by dividing the Case Mix Measure for the home by the Provincial Case Mix Measure and multiplying by 100. The Provincial Case Mix Measure is the measure calculated for all residents of long term care surveyed in the previous year's resident classification process.

The Case Mix Index is used to express the Levels-of-Care requirements of each LTC home and represents the basis upon which Nursing and Personal Care expenditures are authorized. More specifically, the CMI is applied to the NPC rate that is set for all homes in the Province including private and charitable homes multiplied by the number of bed days. The funded amount for the NPC per diem is

based on average care requirements (CMI=100) in long term care homes. If a LTC home has higher than average care levels (CMI>100), the per diem is greater by the percentage over 100, conversely, if the home has lower than average care levels (CMI<100), the per diem is less by the percentage under 100. The chart below shows an example based upon the City homes' CMI and provincial rates for December 2007. The chart shows that if the City increased its CMI, it would receive $1.6 million annually in increased subsidy. Basic resident revenues are subtracted from all subsidies.

A	B	C	D=B*C/100	E	F=D*E*30.416	G=B*E*30.416	H=F-G	I=H*12
Sample using Dec. 07	Monthly NPC	ADJ CMI	NPC after applying CMI/100	beds	$ NPC Monthly Subsidy (30.416 days)	NPC Monthly Subsidy for CMI = 100	Difference	Annual
CL	73.69	95.92	$70.68	160	$343,985.24	$58,616.81	-$14,631.57	-$175,578.79
GJA	73.69	90.39	$66.61	180	$364,672.95	$403,443.91	-$38,770.96	-$465,251.51
CAC	73.69	84.41	$62.20	160	$302,708.45	$358,616.81	-$55,908.36	-$670,900.32
PDC	73.69	93.95	$69.23	211	$444,313.90	$472,925.91	-$28,612.02	-$343,344.21
Total All					$1,455,680.53	$1,593,603.43	-$137,922.90	-$1,655,074.84