



Office of the Auditor General / Bureau du vérificateur général

FOLLOW-UP TO THE 2008 AUDIT OF THE

LONG TERM CARE BRANCH

2010

SUIVI DE LA VÉRIFICATION DE LA DIRECTION DES SOINS

DE LONGUE DURÉE DE 2008

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EXECUTIVE SUMMARY

Introduction

The Follow-up to the 2008 Audit of the Long Term Care Branch was included in the Auditor General's Audit Plan.

The key findings of the original 2008 audit included:

- The City's Long Term Care Branch needs to strengthen its processes for managing residents' trust accounts. The audit found that there were charges to residents' trust accounts that did not have appropriate documentation or authorization, and staff in the homes do not have access to adequate information to determine whether or not a particular charge can be made to a resident's account.
- Overall, the Branch is providing quality care to residents living in the well-maintained City homes. However, the report makes a number of recommendations for improvement and suggests that the Branch:
 - Develop policies and procedures for the management of trust accounts that are reflective of legislative standards and regulations and which clearly define the respective roles and responsibilities;
 - Implement an annual review process for each resident/family to ensure that the fees charged to the trust are agreed to;
 - Review the legislative standard for mandatory training, measure adherence and revise accordingly;
 - Develop a process by which compliance plans are centrally vetted prior to submission for consistency; and,
 - Review purchasing practices to ensure appropriate segregation of duties, and that documentation and settlement processes are implemented.

Since the original Audit was undertaken in 2008, a new piece of legislation governing the operations of all Long Term Care Homes across the province has been put into force. As of July 1, 2010, the City of Ottawa Long Term Care Homes are required to comply with the Long-Term Care Homes Act, 2007 and its regulations. This legislation and its regulations have brought substantial change to the sector. While the Branch and its four homes have been diligent in responding to these new requirements, this follow-up audit review is not intended to assess operations as per the LTCH Act. Rather, the review of the recommendations and the assessment of percentage completion are based on or consistent with the requirements at the time of the original audit in 2008.

Summary of the Level of Completion

1. The table below outlines our assessment of the level of completion of each recommendation as of February 16, 2011.

CATEGORY	% COMPLETE	RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	PERCENTAGE OF TOTAL RECOMMENDATIONS
LITTLE OR NO ACTION	0 – 24	-	-	-
ACTION INITIATED	25 – 49	27, 56, 57	3	4%
PARTIALLY COMPLETE	50 – 74	2, 39	2	3%
SUBSTANTIALLY COMPLETE	75 – 99	6, 17, 30, 43, 45, 46, 47, 48, 49, 50, 59	11	15%
COMPLETE	100	1, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 44, 51, 52, 53, 54, 55, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75	59	79%
TOTAL			75	100%

2. The table below outlines management’s assessment of the level of completion of each recommendation as of Winter 2011 in response to the OAG assessment. These assessments have not been audited.

CATEGORY	% COMPLETE	RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	PERCENTAGE OF TOTAL RECOMMENDATIONS
LITTLE OR NO ACTION	0 – 24	27	1	1%
ACTION INITIATED	25 – 49	-	-	-
PARTIALLY COMPLETE	50 – 74	39	1	1%
SUBSTANTIALLY COMPLETE	75 – 99	17, 47, 48, 49, 56, 57, 59	7	10%
COMPLETE	100	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 45, 46, 50, 51, 52, 53, 54, 55, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75	66	88%
TOTAL			75	100%

Conclusion

In conclusion, we found that there has been significant effort over the past two years by the Branch to meet the recommendations contained in the original audit. The Branch has evolved significantly whereby the four homes work together for the overall benefit of residents. There is evidence of growth and evolution of the “Branch” model with standardization in practice and Functional Teams success. This can only be done with strong leadership, which we witnessed. For some recommendations, although there remains minor action to be completed, a rating of 100% complete has been given.

This has occurred in a time of significant change in the long term care sector. There are clear partnerships being formed between the Branch and the corporate services such as the FSU, Public Works, Corporate Health and Safety and Infrastructure Services. Further, implementation of systems and technologies supported by Information Technology Services and the vendor partners has improved efficiencies and effectiveness at the operational level. Managers and staff have embraced the changes and have supported their staff throughout the changes. This is not to say that there are no outstanding recommendations, such as trust management policies. However, management has indicated that these items are being addressed and evidence indicates that this is the case.

We witnessed a highly motivated group of professionals that share a common purpose and commitment to improvement and quality. The resident and family surveys clearly show that the service provided by the homes is excellent and continues to improve.

Acknowledgement

We wish to express our appreciation for the cooperation and assistance afforded the audit team by management.

RÉSUMÉ

Introduction

Le Suivi de la vérification de la Direction des soins de longue durée de 2008 était prévu dans le Plan du vérificateur général.

Les principales constatations de la vérification de 2008 sont les suivantes :

- La Direction des soins de longue durée doit renforcer ses procédés de gestion des comptes en fiducie des résidents. La vérification constate que des frais étaient portés aux comptes en fiducie des résidents sans documentation ou autorisation adéquate. Le personnel des résidences ne dispose pas des renseignements nécessaires pour déterminer si des frais précis peuvent être portés au compte d'un résident.
- Dans l'ensemble, la Direction prodigue des soins de qualité aux résidents qui vivent dans les foyers bien administrés de la Ville. Cependant, le rapport émet un certain nombre de recommandations d'améliorations et propose que la Direction :
 - Élabore des politiques et des procédures de gestion des comptes en fiducie qui reflètent les normes et les règlements législatifs et qui définissent clairement les rôles et les responsabilités de chacun;
 - Mette en œuvre un processus d'examen annuel pour que chaque résident ou famille s'assure que les frais facturés à la fiducie sont autorisés;
 - Passe en revue la norme législative de formation obligatoire, évalue la conformité et la mette à jour en conséquence;
 - Élabore un processus par lequel les plans de conformité sont validés au niveau central avant leur soumission afin d'en assurer l'uniformité; et
 - Passe en revue les pratiques d'achat afin d'assurer la séparation adéquate des responsabilités et la mise en œuvre de ces processus de documentation et de règlement.

Depuis la réalisation de la vérification originale en 2008, une nouvelle loi régissant l'exploitation des foyers de soins de longue durée de la province est entrée en vigueur. Depuis le 1^{er} juillet 2010, les foyers de soins de longue durée de la Ville d'Ottawa sont tenus de respecter la *Loi de 2007 sur les foyers de soins de longue durée* et ses règlements. La Loi et ses règlements ont apporté des changements importants dans ce domaine. Même si la Direction et ses quatre foyers ont satisfait avec diligence à ces nouvelles exigences, l'examen de la vérification de suivi ne vise pas à évaluer leur exploitation en vertu de la Loi. L'examen des recommandations et l'évaluation du degré d'achèvement sont plutôt fondés sur les exigences au moment de la vérification originale en 2008 ou y correspondent.

Sommaire du degré d'achèvement

1. Le tableau ci-dessous présente notre évaluation du degré d'achèvement de chaque recommandation au 16 février 2011 :

CATÉGORIE	POURCENTAGE COMPLÉTÉ	RECOMMANDATIONS	NOMBRE DE RECOMMANDATIONS	POURCENTAGE DU TOTAL DES RECOMMANDATIONS
PEU OU PAS DE MESURES PRISES	0 – 24	-	-	- %
ACTION AMORCÉE	25 – 49	27, 56, 57	3	4 %
COMPLÉTÉE EN PARTIE	50 – 74	2, 39	2	3 %
PRATIQUEMENT COMPLÉTÉE	75 – 99	6, 17, 30, 43, 45, 46, 47, 48, 49, 50, 59	11	15 %
COMPLÉTÉE	100	1, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 44, 51, 52, 53, 54, 55, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75	59	79 %
TOTAL			75	100 %

2. Le tableau ci-dessous présente l'évaluation de la direction concernant le degré de réalisation de chaque recommandation à l'hiver 2011 en réponse à l'évaluation du Bureau du vérificateur général. Ces évaluations n'ont pas fait l'objet d'une vérification.

CATÉGORIE	POURCENTAGE COMPLÉTÉ	RECOMMANDATIONS	NOMBRE DE RECOMMANDATIONS	POURCENTAGE DU TOTAL DES RECOMMANDATIONS
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TOTAL			75	100 %

Conclusion

En conclusion, nous trouvons que la Direction a réalisé des efforts importants au cours des deux dernières années afin de satisfaire aux recommandations exposées dans la vérification originale. La Direction a grandement évolué afin que les foyers travaillent ensemble pour le plus grand bénéfice des résidents. Il existe des preuves de la croissance et de l'évolution du modèle de la « Direction » par le biais de la normalisation des pratiques et du succès des équipes fonctionnelles, ce qui ne peut être atteint que grâce à un fort leadership, dont nous avons été témoins. En ce qui a trait à certaines recommandations, bien que de petites mesures restent à être finalisées, un degré d'achèvement de 100 % a été accordé.

Le tout est arrivé à un moment où des changements importants prenaient place dans le secteur des soins de longue durée. Des partenariats distincts ont été établis entre la Direction et les services municipaux tels que l'Unité des services financiers, Travaux publics, Santé et Sécurité municipales et Services d'infrastructure. De plus, la mise en œuvre de systèmes et de technologies soutenues par le Service de technologie de l'information et les partenaires fournisseurs a permis d'augmenter les économies et l'efficacité au niveau opérationnel. Les gestionnaires et le personnel ont accepté les changements et ont appuyé leur personnel tout au long de la mise en place de ces changements. Cela ne veut pas dire pour autant qu'il n'y a aucune recommandation en suspens, comme les politiques en matière de gestion fiduciaire. Toutefois, la direction a indiqué qu'elle traite ces points, ce dont les preuves attestent.

Nous avons vu un groupe de professionnels très motivés qui partagent un objectif commun et en engagement envers l'amélioration et la qualité. Les sondages des résidents et des familles indiquent clairement que le service fourni par les foyers est excellent et continue de s'améliorer.

Remerciements

Nous tenons à remercier la direction pour la coopération et l'assistance accordées à l'équipe de vérification.

1 INTRODUCTION

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2 KEY FINDINGS OF THE ORIGINAL 2008 AUDIT

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 provides 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.

3 STATUS OF IMPLEMENTATION OF 2008 AUDIT RECOMMENDATIONS

2008 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.).

2008 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.

Management Representation of the Status of Implementation of Recommendation 1 as of September 30, 2010

Program Admin Clerks and Best Practice Coordinators were trained on the new SAP training module on January 19/20, 2009. Communication was sent to managers, with screenshots on the SAP Training Module, on April 14, 2009. Policy and Procedure 750:92 was revised on October 7, 2009 to reflect changes and the process for obtaining statistical information. To confirm the process, communication was also sent to managers via an admin newsletter on October 9, 2009.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 1

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

Staffing statistics related to training were accessible by managers in the homes. The intent of the recommendation was to confirm that legislative requirements were being met. With respect to registered staff, managers receive an annual report on the status of their respective registered staff registration. We note that Branch's Policy 305.03 "Annual Verification and Proof of Renewal of License: Registered Staff" requires that "In accordance with sections 75 (1) and 86 of the Health Discipline Act, Homes operated by the City of Ottawa shall ensure that each Registered Nurse and Registered Practical Nurse is a holder of a valid certificate of competence from the College of Nurses of Ontario". The policy also states that "It is the responsibility of each registered nurse and registered practical nurse employed at the home to submit his or her renewed certificate of competence to the staffing coordinator by February 15th of every year." However, the policy does not clearly define the ramifications should the relevant certificate not be received and/or verified by the deadline.

According to management's policy work plan, this policy is slated for review in the second quarter of 2011. It is recommended that the policy include the detailed procedures to verify that the certificates have been renewed and in the

event that the certificates have not been renewed that the ramifications are clearly outlined.

OAG: % complete *100%*

Management Representation of Status of Implementation of Recommendation 1 as of Winter 2011

Management agrees with the OAG's follow-up assessment.

An established process is already in place and will be documented more clearly in the existing policy and procedure by Q2 2011.

Management: % complete *100%*

2008 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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 2 as of September 30, 2010

To ensure 100% completion of training by all full-time, part-time and casual staff members in the new LTCHA, one-time funds from the MOHLTC are being used to offer 25 full-day training sessions for all staff during Q4 2010. On-going funding for this model will be brought forward as an identified pressure in the LTC 2011 budget.

Management: % complete *50%*

OAG's Follow-up Audit Findings regarding Recommendation 2

We agree with management that this recommendation is 50% complete.

We note that there were additional monies provided by the MOHLTC for staff training as a one-time funding initiative for 2010. With this funding, the Branch developed and delivered a successful training program and met its commitment for mandatory training for 2010. The Branch did not meet the MOHLTC requirement for 100% participation in 2009. The Branch has indicated, and the FSU confirmed, a budget pressure request for 2011 was submitted to replicate the successful training program of 2010. A review of the 2011 draft budget documents found on Ottawa.ca showed an amount of \$570,000 was allocated to changes due to legislative requirements including mandatory training.

However, at the time of the audit, no confirmation of the 2011 budget request was available and no contingency plan has been developed should the request not be approved. There is concern associated with the ongoing sustainability of the mandatory training program as per the requirements of the *Long-Term Care Homes Act, 2007*. In our opinion, in order to fully implement this recommendation, the Branch and City would need to develop contingency plans to ensure that mandatory training be met on an ongoing basis.

OAG: % complete

50%

Management Representation of Status of Implementation of Recommendation 2 as of Winter 2011

Management agrees with the OAG's follow-up audit finding however further progress has been made.

The requirement for ongoing mandatory training funds submitted as a 2011 budget pressure, was approved by Council. Furthermore, by the end of Q4 2010 LTC staff had completed mandatory training requirements. Therefore 100% of staff in the workplace attended all annual mandatory training as defined by MOHLTC standards.

Management: % complete

100%

2008 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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 3 as of September 30, 2010

Policy and Procedure 750:97 was revised to clarify the compliance plan process and was communicated to all managers on April 4, 2009 and again on October 9, 2009 via an admin newsletter. As of April 4, 2009, reports, including the compliance advisor report, unmet standards and observations report, as well as the compliance plan, are posted electronically.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 3

We agree with management that this recommendation is fully implemented. Branch Management Team (BMT) and Functional Teams meeting minutes reflect discussions regarding compliance visits and the response. Managers are able to access all Ministry of Health and Long-Term Care reports (including compliance plans) on Ozone. We also note that there have been changes to the Compliance Plans policy (Policy 750:97) effective January 2010, which reflects this practice.

OAG: % complete 100%

2008 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.).

2008 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.

Management Representation of the Status of Implementation of Recommendation 4 as of September 30, 2010

The location of LTC-specific policies by service area was reviewed during the cycle review in the summer of 2009. As a result, Home, office and branch policies and procedures were combined into one Administration section in June 2009. Four tables of contents were also created to divide policies and procedures into appropriate discrete sections.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 4

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

The Branch has undertaken a comprehensive policy review process and has categorized the policies by main topic in all areas except for administration. We recommend that the administration policy and procedure manual be organized in a manner consistent with the other manuals. That is, headings should be developed based upon the subject matter such as admission, security and trust account management. The numbering system should be revamped to group these policies together for ease of access for staff and to ensure that they are aware of all of the policies related to specific subjects.

OAG: % complete **100%**

Management Representation of Status of Implementation of Recommendation 4 as of Winter 2011

Management agrees with the OAG's follow-up assessment.

Policies and procedures are reviewed annually in LTC. This further sectioning of the administrative policy and procedure manual will be considered as part of the annual review in 2011.

Management: % complete **100%**

2008 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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 5 as of September 30, 2010

As indicated in the Management Response above, a system is already in place with respect to the location and responsibility for updating policy and procedure manuals. The location of LTC-specific policies by service area was, however, reviewed during the cycle review, in the summer of 2009.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 5

We agree that this recommendation is fully implemented. We confirmed that staff and managers are aware of the locations of the policy manuals and the policies and procedures they contained were the most current versions. We observed the posters containing the new and/or revised policies and procedures on the bulletin boards. We did note that some of these posters did not include an effective date and/or were not signed by the manager as required by policy 750:71 "Accountability Notice for Policies and Procedures" dated February 2009. We recommend that management review policies 750:44 and 750:71 to ensure that they are consistent and cross-referenced to each other or, in the alternative, merged into one policy.

OAG: % complete 100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 6 as of September 30, 2010

The policy and procedure, developed in 2006 and refreshed in 2008, was redistributed to all managers in June 2009 along with the policy and procedure review process map.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 6

We are of the opinion that this recommendation is 80% complete.

The Branch has developed Policy 750:44 "Policy/Procedure Review". This policy requires that all policies, Branch or home-specific, be reviewed by the Functional Teams at minimum every five years unless there is a regulatory change. There is delegated authority for each policy category. Management indicated that home-specific policies relate primarily to physical plant differences. For example, the emergency plans have some home specificity.

We found, however, that there are some home-specific practices/worksheets being utilized that are inconsistent with policy and/or are without policy direction. For example, Policy 700:54 (750:87) "Meal Ticket Sales for Residents' Visitors" requires that meal tickets be numbered including the year of sale. In one home, the meal tickets are numbered, but no year is indicated; conversely, in another home, the meal tickets are not numbered at all. Further, we found that meal costs were different between these homes without specific costing study to support these differences. As well, there is no policy in place in order to establish these costs or to set out the frequency of review of these costs.

We also noted that practices with respect to security and access cards are also different in each home. However, these home specific policies and procedures are not documented. While we recognize that it may be appropriate for these differences, some key controls need to be documented in written procedures. Staff were not aware of the requirements contained in these policies and have developed their own practices.

OAG: % complete **80%**

Management Representation of Status of Implementation of Recommendation 6 as of Winter 2011

Management agrees with the OAG's follow-up audit finding, however, further progress has been made.

The two specific issues referenced above have been addressed. Upon review of policy and procedure 750:44 it was noted that there is no specific requirement to document and bring forward home specific policies for approval by the LTC management team. This revision was made to the policy as of April 1, 2011.

Management considers implementation of this recommendation to be complete.

Management: % complete **100%**

2008 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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 7 as of September 30, 2010

Three-year work plans have been developed and are presently in place for all policies and procedures in the Branch.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 7

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

It is suggested that the policy review work plan include the last date of review to automatically trigger the next date of review. It was also noted that the terms of reference for Functional Teams include the responsibility to develop and approve required policies. Although there has been significant work in this area, it is our observation that a number of policies have not been reviewed consistent with the due date contained in the policy review work plan. These target dates need to be reviewed and the work plan updated accordingly. We also noted that the trust

policy reviews are slated for review in the first quarter of 2011. As discussed later in this report, given the findings as well as the changes in the new Long-Term Care Homes Act and regulations, it is imperative that these policies be updated as soon as possible to reduce risk and clarify the new requirements.

OAG: % complete

100%

2008 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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 8 as of September 30, 2010

The Occupational Health and Safety division assisted LTC with a review of their health and safety policies. As a result, the policy and procedure (900-01) regarding outbreaks in LTC was modified to ensure compliance with the MOL.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 8

A review of the joint health and safety agendas and minutes did indicate that all 48 Health and Safety policies and procedures were reviewed within the context of the Occupational Health and Safety Act as it relates to a health care setting following the original audit recommendation in 2008 and before the follow-up audit in 2011. Beyond the scope of this recommendation, Long Term Care has a 3 to 5 year policy review schedule for all policies and procedures in the Branch. There were policies and procedures slated to be reviewed in 2010 that were not completed at the time of the follow-up audit, but they had been previously reviewed at least once in the 3-year period following the 2008 audit. Some policies and procedures were delayed in being reviewed during Q2-Q4 2010 and others will be delayed for review in Q1-Q2 in 2011 due to the urgent need to develop 16 new mandatory program frameworks to be ready for inspections under the new LTC Homes Act. LTC has a staged approach to policy review so that as required shifts to work plan schedules can be made to respond to more urgent requirements in the LTC system.

Policies 845.02 (Capping of Needles) and 845.03 (Needle Stick Injury) were revised in December 2008. The City of Ottawa LTC Homes started purchasing only safety engineered needles or syringes in 2008, in advance of the legislative requirement. At

the time of review in 2008, these two policies and procedures were still required as the health care sector was awaiting the availability of safety engineered products for diabetic insulin pens. These products are now manufactured using safety engineering processes and no longer require needle capping. Branch Policy 845:02 regarding re-capping of needles does not meet the requirements of the Occupational Health and Safety Act. However, it is important to note that LTC still requires these two policies as there is one type of non-safety needle that arrives at the homes preloaded from hospital for residents returning post fracture. Until this product becomes safety engineered the LTC Branch will continue to require policies 845.02 and 845.03.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 9 as of September 30, 2010

The new Qmentum survey for Accreditation Canada measures the organization's effectiveness in the area of communication. This survey was completed in the fall of 2008. A series of staff "Did you know?" communication bulletins were produced to address the deficient areas. This survey will be implemented every three years as part of the accreditation process.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 9

We are of the opinion that this recommendation is 100% complete. We found evidence that the Branch has implemented a variety of new methods for communicating changes to policies including "Google Eyes" and "Did You Know" posters. From randomly selected staff, there were mixed responses related to the familiarity and effectiveness of these two tools; it is recognized that these tools are relatively recent initiatives. Consistent posting and manners of

display/distribution throughout staff areas and presentation at house meetings in all homes will reinforce the impact of these creative methods of communication.

Further to the original recommendation, it is suggested that methods be measured for effectiveness whereby in subsequent employee satisfaction surveys a specific question be posed querying staff's awareness of and opinions with respect to these communication methods.

OAG: % complete **100%**

Recommendation 10

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 10 as of September 30, 2010

The terms of reference for Functional Teams was reviewed in Q1 2009 and the specific responsibility for policy and procedure review was documented in May 2009 to improve consistency in practice. It is posted on Ozone.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 10

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

A review of terms of reference for each committee as well as a sample of agendas and minutes clearly indicate that policies and procedures are reviewed by committees on a regular basis with the exception of administrative policies. In discussions with administrative staff, although they were aware of the process for policy change, they were unaware of the changes made. The health and safety committee in one home was in transition with respect to the template which was not always utilized. However, the Co-chair of the committee indicated that the new template would be used consistently on a go forward basis.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 11 as of September 30, 2010

In Q1 2009 the LTC Branch reviewed the terms of reference for all committees and created master templates where appropriate. It was determined as part of this work that an FTE would be required to fully implement the recommendation. This budget pressure was considered by the Long Term Care Branch as part of the 2010 budget exercise. This budget pressure was of lower priority than other initiatives being considered by the branch, and was, therefore, not pursued.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 11

We are of the opinion that this recommendation is fully implemented. We took a random sample of agendas and minutes from various committees and confirmed that the comprehensive agenda and minute templates are being utilized by a number of the committees as identified by the Management Response. The organization is encouraged to continue its transition of all minutes to the consistent templates. The template is well designed and action oriented.

OAG: % complete **100%**

Recommendation 12

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 12 as of September 30, 2010

This recommendation has not been implemented due to the reasons outlined in the Management Response.

Specifically, a long term care comprehensive communication plan has been developed and was implemented in June 2009. A monthly newsletter is distributed to all staff in all service areas from the Long Term Care Branch.

Management: % complete *0%*

OAG's Follow-up Audit Findings regarding Recommendation 12

Although the Branch disagreed with this recommendation, it has developed a monthly newsletter that contains information from the home as well as the Branch.

OAG: % complete *100%*

Recommendation 13

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 13 as of September 30, 2010

On November 12, 2008, purchasing practices were reviewed to ensure segregation of duties (purchasing card transactions, ordering, receipt of goods). As a result, the storekeeper must seek manager approval prior to making any purchases on their behalf (VISA card) and charging items to their cost centre. In addition, to ensure segregation of duties, program support clerks will verify packing slips against deliveries, the storekeeper will continue to make purchases and the manager will pay invoices.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 13

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

From a random selection of managers that were interviewed, each was able to demonstrate the segregation of duties. Managers fully understood the delegation of authorities and confirmed that the storekeeper is required to obtain prior authorization for all purchases. The FSU confirmed that this new practice is in place. However, there has been no specific policy and procedure put in place. We recommend, as outlined in Recommendation 72 of this report, that the inventory management and purchasing card processes be developed as they apply to the Long Term Care Branch.

While the corporate purchasing policies and purchasing card policy and procedures provide guidance with respect to general purchasing, the Long Term Care Branch has unique processes. The Branch utilizes a store person for purchasing and inventory management of some items while management undertakes similar purchasing for other items (e.g., food). Since food service differs between homes, it would seem reasonable that the policies would have home-specific elements.

OAG: % complete **100%**

Management Representation of Status of Implementation of Recommendation 13 as of Winter 2011

Management agrees with the OAG's follow-up assessment.

The duties have been segregated and the process will be captured in a policy and procedure as part of the 2011 administrative policy review by Q4 2011.

Management: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 14 as of September 30, 2010

As indicated in the Management Response above, LTC is compliant with corporate purchasing card policy and procedures. All transactions are reviewed by the FSU on an ongoing basis.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 14

We agree with management that this recommendation is fully implemented. In consultation with the FSU, the Branch implemented procedural changes to ensure that the store person obtains prior written authorization from the manager when purchasing on their behalf.

OAG: % complete 100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 15 as of September 30, 2010

This recommendation has not been implemented due to the reasons outlined in the Management Response.

Specifically, responsibility for the Managers' Toolkit has been assigned to the Manager of LTC Support. The Toolkit will be reviewed on a quarterly basis to ensure information is up-to-date.

Management: % complete *0%*

OAG's Follow-up Audit Findings regarding Recommendation 15

We are of the opinion that this recommendation is fully implemented. Although management disagreed with the recommendation, the review of the Managers' Tool Kit at the homes revealed that it has been updated and is utilized by managers. Managers indicated that this Tool Kit is an invaluable source for orientation and reference purposes.

OAG: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 16 as of September 30, 2010

A standardized work planning process is in place as per the Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 16

We are of the opinion that this recommendation is fully implemented. Each year, the Branch undertakes an annual planning process for all homes. This involves the development of the strategic plan supplemented with project charters to initiate specific projects with resources and timeframes. Managers and staff were well aware of this process and provided significant amount of input through the Functional Teams to the Branch Management Team. We suggest that the project charter be supplemented with project status reports that are provided to the BMT on a regular basis. This will allow management to assess progress and address any issues that may hinder the completion of the project. Some of the project charters lacked details. For example, the project to implement LEAN management was vague. Considering that LEAN is a management philosophy rather than a specific project, we were unclear as to the ultimate outcome. However, we understand that these charters are expanded when initiated by the team. Managers interviewed had excellent understanding of the objective of the projects.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 17 as of September 30, 2010

A new Corporate Vacancy Allowance policy was approved by Executive Management Committee, which established a gapping rate of 1.6% per department.

Regular monthly operating reports, including compensation costs, are provided by the FSU. To supplement the cost data, HR reports on 'hours by position' are also provided when requested and training on how to run these reports has also been offered. Analysis of the hours and cost data is provided by the FSU thereby assisting managers to effectively manage their resources.

A review of the Personnel Cost Planning (PCP) tool by the Financial Management Information Systems group has been completed and has identified that the current configuration of the product does not allow for the type of reporting on gapping that is required. Finance has included a project for enhanced SAP reporting in their 2011 Service Excellence plan. This project will include a gapping report. Management expects to complete this recommendation by the end of Q4 2011.

Management: % complete 95%

OAG's Follow-up Audit Findings regarding Recommendation 17

We agree with management that this recommendation is 95% complete. The corporate policy regarding vacancies contains a target of 1.6% reduction in compensation costs. Management indicated that it understands these requirements and is provided with reports to manage this target. We reviewed the monthly reports provided to management which shows financial results as required in the provincial format (by envelope) and by management format (organization basis by envelope). The information is further broken down with respect to compensation. The Personal Planning Tool also provides improved budgeting tools but is not intended to address the ongoing gapping. We note that, as of November 2010, the Branch's financial results indicate that the gap would not be met. Management indicated that staffing replacement was undertaken based upon mandatory requirements and minimum staffing requirements based upon legislation. Therefore, it is challenging to meet the gapping requirement while complying with legislation.

OAG: % complete 95%

Management Representation of Status of Implementation of Recommendation 17 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The status of implementation has not changed since that provided as at September 30, 2010.

Management expects to complete implementation of this recommendation by the end of Q4 2011.

Management: % complete

95%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 18 as of September 30, 2010

This recommendation has not been implemented due to the reasons outlined in the management response.

Specifically, LTC Branch continues to have 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. Preferred accommodation revenue remains high: 98% for 2009, and 98% as of the end of September 2010.

Management: % complete

0%

OAG's Follow-up Audit Findings regarding Recommendation 18

We are of the opinion that this recommendation is 100% completed, however there remain some issues regarding preferred accommodation. When a resident is admitted to the home, the available bed may be a private or semi-private room and yet the resident may be unable to pay preferred rates or does not desire to be placed in a preferred bed. Section 260 of Ontario Regulation 79/10 requires that "Every licensee of a long-term care home shall ensure that no more than 60 per cent of the licensed bed capacity of the home is designated as preferred accommodation."

Because the four homes have more than 60% preferred beds, the Branch must place residents paying basic rate into preferred beds. The Branch makes every attempt to move residents from preferred beds to basic accommodation beds but there is no policy that outlines this requirement to residents. While the admission agreement addresses this issue to some extent, the current policy and/or practice is not formalized.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 19 as of September 30, 2010

Communication was sent to social workers on November 24, 2008, which included instructions on running the abovementioned reports in Goldcare.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 19

We are of the opinion that this recommendation is fully implemented.

The social workers receive a monthly report from the FSU showing occupancy rates, numbers of admissions and discharges, accommodation distribution, etc. Social workers appear to use this report as a verification of their own records. While the social workers acknowledged access to reports from Goldcare, not all are generating such reports routinely. There continues to be a reliance on personal strategies for monitoring bed occupancies by accommodation rate with confidence in these strategies for maintaining the 60/40 ratio. Several noted that in their absence, this ratio is often not maintained and requires adjustment upon their return.

There appears to be improvement in consistently achieving the 60/40 ratio in accommodation rates across the homes. The room distribution at Carleton Lodge continues to pose challenges in that rooms are not designated by accommodation rate rather individual residents are associated with accommodation rate. This appears to result in numerous moves within the home. It also occasionally causes

an issue for residents living in a private room paying private preferred accommodation rates when they come to know others are living in identical accommodation but paying basic rate (where it cannot be attributed to a care need/high intensity funding).

OAG: % complete **100%**

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).

2008 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.

Management Representation of the Status of Implementation of Recommendation 20 as of September 30, 2010

The Long-Term Care Program Manual provides limited directives for eligible expenditures within funding envelopes. OANHSS is currently working on a recommendation to the MOHLTC that provides for clarification and consistency of eligible expenditures for all LTC operators.

In July 2009, the Branch and FSU reviewed envelope eligibility which resulted in the reallocation of dietician charges to Program Support Service. The FSU will continue to review eligible expenditures with the LTC Administration Team.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 20

We are of the opinion that this recommendation is fully implemented.

The FSU is now receiving documentation from MOHLTC and the Local Health Integration Network (LHIN) on a regular basis, either directly or from the Branch. The FSU undertook an analysis of the costs by envelope and is fully cognizant of the requirements. The FSU monitors the coding by managers and makes adjustments in accordance with the requirements as outlined in Ministry policy. Since the FSU contacts are dedicated to long term care, they are better equipped to monitor these requirements and inform managers when there are coding issues.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 21 as of September 30, 2010

As indicated in the Management Response above, a project plan is in place. Reports are provided to the branch management team to update them on status, results and training activities.

The Goldcare program was adopted to ensure that the City of Ottawa Long Term Care Homes were prepared to implement the provincial RAI MDS resident assessment system. The Province is presently reviewing the funding formula that will accompany the care levels resulting from this new system.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 21

We are of the opinion that this recommendation is fully implemented. There is a Resident Care Information Steering Committee in place which has specific goals and objectives. The Committee has broadened its mandate beyond its original focus on RAI-MDS now that this system has been implemented in the homes. As well, the project plan and status reports indicate a successful implementation and positive results from the staff perspective.

OAG: % complete **100%**

Recommendation 22

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 22 as of September 30, 2010

This was in practice at the time of the audit as per the Management Response above.

Management: % complete **100%**

OAG’s Follow-up Audit Findings regarding Recommendation 22

We are of the opinion that this recommendation is fully implemented.

A consistent process is in place to review the homes’ progress with RAI-MDS and its opportunities to maximize potential funding. The Branch continues to monitor its CMI following Goldcare implementation which shows improvement.

Management and staff both indicated that the implementation has resulted in improved documentation and attention to acuity of resident care. The chart below shows the change in CMI between 2007 and 2010. These represent significant increases in revenues for the City. In 2007, the CMI results indicated that it received \$137,922 (9%) less than it would if it had a CMI of 100. In 2010, the amount of loss is reduced to \$70,176 (4%). That is, the Branch has made significant impact with the implementation of Goldcare and documentation representing an increase in funding of approximately \$67,746 annually. Continued improvement is likely as staff and management become more comfortable with the system and the documentation requirements.

Home	CMI 2007	CMI 2010	Percentage Change
CL	95.92	99.53	104%
GJA	90.39	92.79	103%
CAC	84.41	95.62	113%
PDC	93.95	96.57	103%

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 23 as of September 30, 2010

Effective January 1, 2008, all high intensity need claims to the MOHLTC and the receipt of the corresponding recovery, are documented by the FSU.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 23

We are of the opinion that this recommendation is fully implemented.

The Branch forwards the high intensity needs and lab submissions to the FSU. The FSU and the Branch work together to ensure that the high intensity needs and lab submissions reflect actual costs and are properly reconciled and accrued in the appropriate period.

OAG: % complete 100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 24 as of September 30, 2010

The Ministry of Health and Long Term Care revised the High Intensity Program in Q3 2009. City Homes have revised their policy and procedures within the parameters of the new system to ensure all cost recovery activities are maximized.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 24

We are of the opinion that this recommendation is fully implemented. The FSU and the Branch have undertaken a review of the high intensity needs charges and claims in order to ensure that the charges are coded to the right accounts. The FSU monitors the invoices and follows up with the Branch when the charges are related to high intensity needs to ensure full recovery. The FSU now monitors the payment notices to ensure that the recoveries are reflected as submitted.

OAG: % complete

100%

Recommendation 25

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 25 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 25

The Branch currently does coordinate grant submissions and as such the recommendation has been fully implemented.

However, beyond the issue of coordination, management indicated that applying for grants is hindered by the budgetary processes. Since many of the grant applications are announced in the middle of the fiscal year, the Branch is often unable to participate. Further, where grants require some matching funding, the Branch is unable to do so within their budget.

We understand some of these challenges; however, in order to reap the rewards of some programs, it is recommended that the Branch explore some options such as

providing a contingency in the budget in order to respond to the in-year grant opportunities. For example, the new graduate initiative aimed at guaranteeing new nurses with full time positions, provided “Temporary Bridging Positions Fully Funded for 6 Months” was not pursued.

These temporary bridging positions were above staffing complement and fully funded by the government for six months. The expectation is that the organization has a plan for these temporary bridging positions to lead to permanent full-time jobs. If the employer was not successful in bridging the new graduate by the end of the six months, the employer had to commit six weeks of additional, above staffing complement bridging time to allow this transition to occur. This initiative was not explored by the Branch due to the funding requirement by the City. However, it is unfortunate for the City to miss out on additional nursing funds that would have a direct benefit to the residents.

The Branch also indicated that grant applications are often time consuming and, with few administrative resources, it is difficult for them to pursue the various opportunities. With respect to the various grant opportunities, the FSU plays only a small reactive role. In order to leverage grant opportunities in an efficient manner, it is recommended that the FSU take on a larger role in pursuing these grants and finding avenues to get in-year approvals. Since the FSU now provides dedicated staff for Long Term Care, it has both the expertise and access to the financial records to provide additional support.

We note, however, that the Long Term Care Branch and Employment and Financial Assistance Branch have initiated a unique project that provides work experience for those on financial assistance who are pursuing the personal support worker certificate. This is very innovative and should be shared as a best practice with other municipalities.

OAG: % complete

100%

Management Representation of Status of Implementation of Recommendation 25 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The Branch coordinates grant program submissions and assists home management with responses, as recommended.

The Long Term Care Branch has no capacity to pursue the recommendations made as part of the follow-up assessment, but beyond the scope of the original recommendation. The Branch will consider related budgetary pressures during the development of the 2012 budget and if accommodated within the 2012 budget, will implement during that year.

Management: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 26 as of September 30, 2010

For OMBI reporting, costs are allocated based on the methodology outlined in the Annual FIR Workbook for Allocation of Program Support, which details the varied cost drivers for corporate overhead charges. Allocated administration costs reported in the Audited Annual Reconciliation Report for the MOHLTC relating to LTC Divisional Administration and the allocation for FSU support, are allocated on a per bed basis. RPAM facility costs are tracked through Internal Orders in SAP by home. Documentation to support the charges is found in the FSU-Social Services shared drive.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 26

We are of the opinion that this recommendation is fully implemented.

The FSU provided detailed calculations as well as the methodology undertaken by the City to allocate administrative costs to long term care. The methodology is consistent between programs and similar to the approach utilized by other municipalities and appears to meet the requirements of the funding agreement with the LHINs/MOHLTC.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 27 as of September 30, 2010

The development of policies and procedures for the management of trust accounting has been delayed until the end of Q1 2011.

Management: % complete *0%*

OAG's Follow-up Audit Findings regarding Recommendation 27

We are of the opinion that this recommendation has been initiated. The FSU and Branch have made some positive procedural changes that have not yet been documented and which are discussed below

In discussions with management and the FSU, policies and procedures with respect to trust management will be undertaken in the first quarter of 2011.

As part of the follow-up we reviewed 40 resident files and found that there were inconsistencies between authorized charges and actual charges. Staff at the homes were not aware of many of the procedures that were put in place to reconcile the trust petty cash accounts or guest meals. Processes were different in each home including different forms, spreadsheets and approvals. In 11 out of 40 files, there were charges to the trust that were not included on the Schedule C. Management was made aware of some of these issues and has since updated the Schedule C to include more items (such as manicures and special meals).

We also noted that the files did not always contain the same information to support charges to the trust accounts. It was very difficult to trace the documents to the resident trust statements. The forms utilized in each home are different resulting in different practices within the resident files. As well, cheques deposited by residents and/or the power of attorney in the trust do not always have supporting documentation or the documentation is not sufficient to determine the source. In the homes, only some cheques were accompanied by a transaction slip. In one sample file, there was a transaction slip for a withdrawal but this did not appear on the trust statement. If there were reconciliations between trust statement, the trust account reconciliation and the documents in the file, this would not occur. We were unable to determine if the withdrawal actually occurred as the reconciliation process of the trust float does not follow an imprest account reconciliation approach. We understand that the Branch has received training with respect to the Corporate Cash Handling Policy and Procedures. We recommend that the Branch policies and procedures refer to those corporate policies.

Further, it is important to note that legislative changes effective July 2010 with respect to trust accounts requires some significant changes, all of which are subject to inspection by the Ministry of Health and Long Term Care. For example, under section 241 of Ontario Regulation 79/10 to the Long-Term Care Homes Act, states:

“(5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,

(a) a system to record the written authorizations required under subsection (8); and

(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money.”

(6) The licensee shall provide a copy of the written policy and procedures to every resident and person acting on behalf of a resident who asks to have money deposited into a trust account.”

As management indicated, these policies and procedures have not yet been developed.

It is recommended that, when the policies and procedures are developed, that all trust management practices be reviewed (including a review of files to gain an understanding of the issues). The procedures should address the following:

- Contents of each resident file at the FSU with requirements to be sent from the home
- Transaction and authorization procedures for all withdrawals, deposits (including cheques), accommodation fees (from trust or direct payments), meals, hairdressing and all other non-regulated services and fees
- Prenumbered forms to be utilized. These should be used as the transaction number within Goldcare to allow a trace of documents to the statement as well as provide the resident with more detailed information
- Reconciliation process upon release of the monthly statements - this should include a process to ensure that the authorizations are received for each transaction and placed in the file. Where there are errors or omissions (such as dates, signatures (staff or resident), incorrect classification of transactions), that these be brought to the attention the staff at the homes to rectify practices
- A trust petty cash reconciliation process for the trust account in each home with financial limits
- Delegations of authority

- Communication with the homes regarding authorized services in Schedule C as well as a mechanism to update the Schedule C if the approved services change in the middle of the year. The spreadsheet prepared by the FSU with the summary of Schedule C services by resident should be shared with the front desk so that they are able to ensure that items such as guest meals and special meals are approved to be charged to the trust

Another area of concern relates to the residents that have a negative balance in their trust accounts. Although the communication from the FSU indicates that the trust account must not have a negative balance, it is not always enforced. Since this means that residents are in effect “borrowing” from other residents, this practice needs to be further documented and enforced.

To illustrate, at December 31, 2010, there were 82 out of 711 (or 12%) residents that had negative balances totally \$4,294 (2% of the positive balances). Of the 82 residents with negative balances the average was \$52, with a maximum of \$426. 27 of the 82 residents had negative balances over \$50. These negative balances indicate that charges to the trust continued even though the resident did not have funds in their account. We are aware that this issue is monitored at the front desk and by the FSU. However, charges from other parts of the home may not be aware of the balances when committing to the service.

OAG: % complete

25%

Management Representation of Status of Implementation of Recommendation 27 as of Winter 2011

Management agrees with the OAG’s follow-up finding.

The development of policies and procedures for the management of resident trust accounting is underway with a draft policy scheduled to be completed by the end of Q2 2011.

Branch administrative staff and the FSU met on February 18, 2011 to discuss the implementation of new procedural changes relating to resident trust accounting transactions. Revised numbered forms for cash withdrawals and meal tickets have been ordered. Resident monthly ledger forms for bar and tuck shop transactions are being developed. The revised forms, processes and procedures are scheduled for implementation by the end of Q2 2011.

The spreadsheet prepared by the FSU with summary Schedule C services by resident will be discontinued. The FSU has confirmed that the administration staff in the homes have access to the trust authorization pop-ups within Goldcare and a demonstration on how to access these data values was presented to LTC administration staff on February 18, 2011.

Management expects implementation of this recommendation to be complete by the end of Q2 2011.

Management: % complete

25%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 28 as of September 30, 2010

As of November 2008, Schedule C of the admission agreement is mailed out to the resident/power of attorney annually by the FSU for approval of services to be charged to resident's trust accounts.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 28

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

The Branch and FSU worked together to update the admission agreements and the Schedule C. This has been updated several times since 2008 and is being continuously improved. We noted, however, that neither the admission agreement, nor the schedules allow for the payment of accommodation fees through the trust account. We also note that significant effort was undertaken to ensure that the Schedule Cs were updated and reflected on the file. All of the 40 sample files reviewed had a Schedule C that was dated within 13 months and an initiative was underway in February 2011 to update these schedules for all residents that were admitted prior to 2010.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 29 as of September 30, 2010

At considerable cost and work effort, consolidated statements were sent to residents/families for the 2008 year-end. The FSU did not receive any responses indicating disagreement. As an efficiency measure, effective November 2009, in lieu of an annual consolidated statement, the FSU will staple a boldly coloured note to the monthly statements requesting that residents/family members review the detailed charges and call the FSU Office should they be in disagreement with any transactions posted to their accounts.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 29

We are of the opinion that this recommendation is fully implemented.

As mentioned above, the FSU undertook a project to update the trust account and admission agreement which included the issuance of a consolidated annual statement. The annual statement production caused some challenges and significant effort by the FSU. As an alternative the FSU now includes coloured reminders to review their monthly statement in detail and contact the FSU with any questions or concerns. The FSU indicated that they receive very few queries; however, the reminders appear to be effective.

The FSU now requires an annual update to the Schedule C of the admission agreement which is designed to ensure that the residents and/or the power of attorney, agrees to allow specific charges to the trust account. The FSU tracks the contents of Schedule C in a spreadsheet and forwards to the home. This is a good practice. However, we found that the spreadsheet was not shared with the front desk and therefore, the staff were not able to verify that charges, such as guest meals, were authorized to be charged to the trust account. Ideally, the staff should be able to access this basic information real-time from the Goldcare system in order to ensure that the most recent information is accessible. Currently, the staff only have the ability to check the balance in the resident accounts. We understand from the FSU and the Branch that this read only access is being investigated.

We also found that the communication to the resident and the power of attorney was not sufficiently clear or may have been misinterpreted. That is, in 2 of the 40 files that we reviewed, it appeared that the resident was under the impression that the annual update was to add services rather than confirm all of the services that could be charged to the account. As well, if the resident requested that additional services be charged to the trust account, the Schedule C was not updated. It is

suggested that the letter sent to the resident and/or power of attorney be clarified to state that the Schedule C replaces all other previously signed Schedule Cs.

OAG: % complete *100%*

Recommendation 30

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 30 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 30

The current resident survey has two questions with respect to administration as follows:

- 1- Efficiency in dealing with my finances/accounting (range from excellent to poor or not applicable) and;
- 2- Availability and helpfulness of the Administration Staff (range from excellent to poor or not applicable).

While this does satisfy the basic intent of the original recommendations, we are of the opinion that these questions are not specific to the services of the FSU but rather of those of the administrative staff in the homes.

The recommendation was intended to discuss the possible questions that the FSU would benefit from and a redesign of the questions in order to provide sufficient guidance for the FSU to benchmark and improve its service. Although the results may not be different than achieved, one would be unable to determine the level of satisfaction with the FSU. In discussions with the FSU, the Branch has not requested specific questions be developed to assess the level of satisfaction of their service.

OAG: % complete *75%*

Management Representation of Status of Implementation of Recommendation 30 as of Winter 2011

Management disagrees with the OAG's follow-up audit finding that implementation of this recommendation is only substantially complete. Although the current survey does not individually address the services of the FSU, Management is of the opinion that the existing satisfaction survey implements this recommendation as is evidenced by family comments on financial services in the survey and in communication with the homes.

Further, it is anticipated that by the end of 2012 the Province will introduce a mandatory resident satisfaction survey. Any adjustments to the existing survey would be redundant in the near future. The issue of survey revision was raised at the joint LTC management and family councils meeting of February 2011 and there was concurrence that a change was not advisable at this time. Management considers implementation of this recommendation to be complete.

Management: % complete **100%**

Recommendation 31

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 31 as of September 30, 2010

See Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 31

We are of the opinion that this recommendation is fully implemented.

Section 241 of O. Reg 79/10 under the Long Term Care Homes Act requires "Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident."

Therefore, the recommendation, although implemented is no longer relevant given the changes to the legislation in 2010.

OAG: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 32 as of September 30, 2010

See Management Response above.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 32

We are of the opinion that this recommendation is fully implemented.

We have reviewed the delegated authority with respect to the trust bank accounts which clearly identifies the current FSU staff as having signing authority.

OAG: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 33 as of September 30, 2010

This recommendation has not been implemented due to the reasons outlined in the management response.

Specifically, LTC Branch continues to receive budget guidelines and parameters from City Council and identify yearly targets through the branch hierarchy which are then reviewed at a branch/departmental level prior to being presented in the draft budget. The Long Range Financial Plan continues to allow the branch to identify required needs within City Operations and the City as a whole.

Management: % complete *0%*

OAG's Follow-up Audit Findings regarding Recommendation 33

We are of the opinion that this recommendation is 100% complete. Although management disagreed with the recommendation, we understand from discussions with managers that their ideas for cost savings as well as pressures are explored and included in the annual budget process.

OAG: % complete *100%*

Recommendation 34

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 34 as of September 30, 2010

A Strategic Branch Review has been completed and all of the recommendations in the report have been implemented as of January 2009.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 34

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

The Branch undertook a Strategic Branch Review as part of a Corporate initiative. The review revealed some savings that have been implemented. Since technology and knowledge constantly change, it is suggested that the Branch develop a continuous improvement plan. Since the Branch has developed a Project Charter for 2010 which focuses on training on LEAN management, it would seem reasonable that LEAN projects will be identified and a long term plan that assesses all major processes will be the natural outcome. We note as well, that, through the Functional Teams, managers have been identifying efficiencies as a normal course of business.

OAG: % complete **100%**

Management Representation of Status of Implementation of Recommendation 34 as of Winter 2011

Management agrees with the OAG’s follow-up assessment.

Of note, LTC has an annual quality improvement (QI) project charter plan. The approach to these QI plans includes, but is not limited to, LEAN.

Management: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 35 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete **100%**

OAG’s Follow-up Audit Findings regarding Recommendation 35

We are of the opinion that this recommendation is fully implemented.

We have reviewed the budgets of the Branch prepared on an annual basis which now clearly show the impacts of budgetary decisions on the subsequent two fiscal years. The capital budgets are prepared on a multi-year basis. We note, however, that the budgets continue to be prepared on a cash basis for adoption. The impact from an accrual basis of accounting is not included in the budget, although must be prepared for financial statement purposes.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 36 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 36

We are of the opinion that this recommendation is fully implemented.

As part of the budget process, the FSU prepares the budget in both an annual total cost format as well as a per resident per day basis in order to perform comparative analysis between homes. Further, the FSU calculates revenues on a per resident per day basis as per provincial funding. In year financial and balance scorecard reports developed by the Branch are also analyzed on a per resident day basis.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 37 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 37

We are of the opinion that this recommendation is fully implemented.

As part of the budget process, Infrastructure Services provides the Branch with the life cycle renew and replacement plan. Condition assessments of the home and its equipment are undertaken on a regular basis and the long term capital plan is developed based upon set criteria. Public Works provides ongoing preventative and reactive maintenance services to the homes and shares the costing information with the Branch. Management indicates that it is fully aware of the long term capital plans and works with Public Works and Infrastructure Services to identify issues and concerns regarding physical plant.

OAG: % complete **100%**

Recommendation 38

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 38 as of September 30, 2010

The FSU prepares monthly operating and capital reports, quarterly variance analyses and forecasts.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 38

We are of the opinion that this recommendation is fully implemented.

The FSU prepares a monthly financial variance report for the homes, which includes the monthly variance to budget and year to date status. The managers utilize the report for a review of their financial status and reporting to the Administrator on variances and actions to be taken. The managers also access SAP prior to the receipt of their variance report from the FSU to monitor their financial status.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 39 as of September 30, 2010

Resident receivables are invoiced in accordance with the Homes for Aged and Rest Homes Act R.R.O. 1990, Regulation 637 Section 39.1 (Resident Payments). Procedures have been documented and can be referenced on the LTC FSU shared directory.

A Concept Value Case was submitted to IT to automate the inventory supply process within the four Long Term Care homes by moving to wireless bar coding technology for inventory tracking and stock distribution in order to achieve efficiencies. The LTC Branch has advised the FSU that the Bar Coding Inventory System submission was rejected as no significant financial savings would be achieved based on use of the technology. In lieu of the Bar Coding Inventory System, further checks and balances were implemented in the Home to ensure protection of assets.

A Tangible Asset spreadsheet has been developed and implemented as per City of Ottawa protocol and has been in place as of September 28, 2009.

Management: % complete ***100%***

OAG's Follow-up Audit Findings regarding Recommendation 39

We are of the opinion that this recommendation is 50% complete.

With respect to inventory management, the Branch developed a Concept Value Case regarding bar coding technology. This was not accepted as cost effective. Although ideally, inventory management should be electronic, a manual system with proper controls can be just as effective.

The Branch reviewed its policy regarding Day Storeroom Operations Policy number 225.14 with respect to food and non-food storage inventory. This policy indicates that the room must be locked at all times. We do not believe that this policy provides sufficient direction for staff with respect to inventory management. Inventory management needs to cover all inventory including medical supplies,

food, personal items (incontinence). The policy and procedures should, at minimum, include the following elements:

- Purchasing levels and appropriate inventory purchase points
- Three way matching process that provide for segregation of duties
- The types of forms to be utilized including numbering systems
- Documentation of inventory processes for removing and adding to inventory (e.g., first in first out, perpetual versus periodic)
- Authorizations for removal of inventory
- Delegations of authority
- Physical count schedule and procedures – segregation of duties between store person and inventory count
- Disposition of excess, obsolete and spoilage processes
- Account reconciliations

As discussed in Recommendation 27, policies and procedures with respect to trust management and accommodations accounts receivable have yet to be initiated. There is a corporate tangible capital asset policy and the Branch is provided specific guidance with respect to the tracking and monitoring of tangible capital assets under their control. The majority of tangible capital assets are managed by Public Works.

OAG: % complete 50%

Management Representation of Status of Implementation of Recommendation 39 as of Winter 2011

Management agrees with the OAG’s follow-up finding.

As confirmed by the OAG, an internal control framework has been developed for accounting of tangible capital assets.

The portion of this recommendation relating to accounts receivable overlaps with Recommendation 27. Please refer to the Management Response under that heading for details.

The portion of this recommendation regarding an internal control framework for inventory will be reviewed in the context of LTC operations. Appropriate revisions to policies and procedures will be made by Q1 2012.

Management: % complete 50%

Recommendation 40

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 40 as of September 30, 2010

LTC reviewed the payroll and scheduling process in consultation with Labour Relations and determined that access cards do not provide reliable evidence of an employee's attendance and thus would not assist in payroll reconciliation.

As anticipated by Section 6.2.5 of the audit, the implementation of the Telestaff software for scheduling has improved payroll controls. Telestaff is presently in place in the four homes. Payroll is downloaded on a daily basis from this software into the payroll system in SAP.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 40

Management has reviewed the potential for access cards to assist in payroll processing and as such has responded to the recommendation.

The implementation of Telestaff has improved tracking and scheduling processes. However, there continues to be a risk that staff is being paid for time that was not worked. The awareness of the issue has resulted in one home delivering an in-service program to address lateness and early departure of staff. The current practice is not reliable as the registered nurse in charge is responsible for reporting staff lateness or early departures throughout the home after regular business hours. It is not possible for the registered nurse to supervise and observe the comings and goings of all staff.

In management's response above, it indicated that "LTC reviewed the payroll and scheduling process in consultation with Labour Relations and determined that access cards do not provide reliable evidence of an employee's attendance and thus would not assist in payroll reconciliation." Long term care experience has long recognized that integrated access cards with scheduling software provide improved reliability of staff presence. In reviewing the Telestaff scheduling software utilized by the Branch, it appears to provide for this functionality and should be further explored with a view to reduce costs. It is recommended that management undertake a "payback period" analysis with respect to the implementation of access cards against savings. We expect that the payback period would be relatively short (2-3 years).

OAG: % complete **100%**

Management Representation of Status of Implementation of Recommendation 40 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The use of access cards as “time punch cards” was reviewed and found to be an unreliable method of time management and of limited assistance from a labour relations perspective.

Management has a process in place to monitor and address lateness. The facility charge nurse is responsible for reporting staff lateness and the relevant manager follows-up with the employee. Most late behaviours are captured and addressed through this process. A practice of random management rounds on evenings, nights and weekends further supports the facility charge nurse in the monitoring of late arrivals.

Beyond the scope of the original recommendation, the add-on for Telestaff, this functionality of a “punch clock” is not available. There is a time card module available, but it is essentially an electronic time sheet, and the cost would not be justified given the attendance management measures already in place. Further, this module is part of the vendor hosted solution, and could potentially contravene the privacy provisions of the MFIPPA. The vendor data centre is located in the United States and the data transmission to their data centre would be subject to the United States Patriot Act which allows for the monitoring of data cross the border and the risk of release of personal data to a foreign government.

Management: % complete ***100%***

Recommendation 41

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 41 as of September 30, 2010

The audit of the 2009 Financial Statements has been completed and the City is PSAB-compliant.

Management: % complete ***100%***

OAG’s Follow-up Audit Findings regarding Recommendation 41

We are of the opinion that this recommendation is fully implemented.

The FSU provides monthly operating reports to the homes. Dedicated FSU staff has had a positive impact on the reporting requirements through ongoing communication and attendance at Branch Management Team meetings.

Management at all levels of the homes stated that there is good support from the FSU. In recent years, the FSU has improved the financial reports in terms of timing and content. The managers have access to SAP and can “drill down” to the required details of their financials. That being said, we suggest that financial reporting requirements be reviewed on a regular basis to match continued relevance to meet strategic goals and legislative requirements.

OAG: % complete *100%*

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).

2008 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.

Management Representation of the Status of Implementation of Recommendation 42 as of September 30, 2010

Present language in the collective agreement prohibits contracting out of these positions unless they are vacant.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 42

We are of the opinion that this recommendation is 100% complete.

We note that the hairdressers are now on one year contracts. A review of the costs may be warranted since the fees for hairdressing (cut and set) have increased from \$27.00 to \$34.50 (a 28% increase) between 2007 and 2010 which represents approximately 7% increase per year, well above inflation.

OAG: % complete *100%*

Recommendation 43

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 43 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 43

We are of the opinion that this recommendation is 75% complete.

We reviewed the costing studies undertaken within the homes to determine the cost of guest meals, meals on wheels and special meals. Although the study is undertaken regularly, there is no set methodology that sets the costs that would be included. As well, we found that the meal rates varied between homes. This is likely appropriate as the meals are prepared in different manners in each home. At Peter D. Clark home, the meals are all ordered premade as the home utilizes retherm systems to prepare food. Champlain's food service is outsourced and therefore, guest meals are charged directly by the service provider. Carleton Lodge and Garry J. Armstrong both prepare food onsite and therefore, it would seem reasonable that these two homes would utilize similar costing methodology. We understand that the Hospitality Functional Team has a plan to address some of these anomalies. We recommend that the methodology be documented (home specific if required) to ensure consistency between homes as well as from year to year.

OAG: % complete **75%**

Management Representation of Status of Implementation of Recommendation 43 as of Winter 2011

Management agrees with the OAG's follow-up audit finding, however, further progress has been made.

The Branch completed an annual review of food costs and recovery rates for Meals on Wheels, family meals, etc. to determine the appropriate rates. Effective March 1, 2011, all meal rates are consistent across the four homes.

Furthermore, and beyond the scope of the original recommendation, a policy and procedure will be developed by Q4 2011 to address the need for annual review of chargeable services.

Management considers implementation of this recommendation to be complete.

Management: % complete **100%**

Recommendation 44

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 44 as of September 30, 2010

This recommendation requires resolution; it has therefore not been implemented.

LTC Homes do not have a fundraising role. Notwithstanding the branch's formal roles and responsibilities, LTC continues to have representation on the Advisory Council of the Prosperity Long Term Care Fund.

Management would be pleased to meet with the auditors undertaking the follow-up assessment in order to achieve resolution.

Management: % complete *0%*

OAG's Follow-up Audit Findings regarding Recommendation 44

We are of the opinion that this recommendation is fully implemented.

Although management disagreed with the recommendation, we found that the Branch has actually undertaken some innovative "fundraising" activities. The original intent of this recommendation may have been misinterpreted. The leadership team of each home was able to clearly identify a number of initiatives that are currently in place to support community partnerships. Furthermore, they identified current activities and recent events geared towards fundraising and generating additional revenue for resident specific initiatives.

OAG: % complete *100%*

Recommendation 45

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 45 as of September 30, 2010

The current policy was re-communicated to all staff responsible for admissions through a Social Worker Functional Team meeting and email in November 2009.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 45

We are of the opinion that the recommendation is 75% implemented.

Although the current policy was re-communicated to all staff responsible for admissions, we found that practices associated with the assembly of the admission package vary by home as do the requirements to be sent to the FSU. Some social workers print the admission agreement directly from Ozone at time of assembly; others rely on the "front desk" to place all documents/forms into the package. The sample admission packages reviewed on-site included the same agreement and other contents. In discussions with front desk staff, there was recognition that there may be packages with old admission agreements and were in the process of review.

Some homes added home-specific information for residents and families in efforts to support their transition into long term care. In our review of the 40 sample resident files at the FSU, the documents sent by the home varied. Some files included the full admission agreements while others only included the financial schedules. As well, in consultation with staff and managers, there was confusion as to the requirements of the FSU. In order to ensure that the most recent admission agreement is always utilized, the social worker and/or the front desk should print the admission agreement directly from Ozone rather than printing ahead of time. As a reminder, the Admission Package Checklist could provide a note to check Ozone for the most recent version.

As discussed in Recommendation 27, this is particularly important in light of the new regulations regarding authorization requirements for all charges to resident trusts.

OAG: % complete *75%*

Management Representation of Status of Implementation of Recommendation 45 as of Winter 2011

Management agrees with the OAG's follow-up audit finding, however, further progress has been made.

As of March 2011 required changes to the admission agreement for the new LTC Homes Act have been made. As of this date all administrative and social work staff have been reminded not to print admission agreements in advance of the admission date. The new requirement for the Administrator to sign the agreement allows an opportunity for random audit of the currency of the agreement.

There will continue to be some variation of materials in each admission kit to reflect the uniqueness of each home's family council priorities.

Management considers implementation of this recommendation to be complete.

Management: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 46 as of September 30, 2010

As indicated in the Management Response above, a process to ensure completeness of the resident business files has been implemented. A detailed Trust Statement incorporating all trust transactions during a resident's stay in the home is placed in the resident's file after discharge. An admission checklist and policy and procedures were developed in August 2009 and implemented in September 2009. The policy and procedures were communicated to social workers and administration staff at the Social Work Functional Team meeting on September 11, 2009.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 46

We are of the opinion that this recommendation is 75% complete.

We note that all admission packages reviewed across the four homes included the "Admission Package Checklist". The Social Workers interviewed during the audit were consistent in their description of its purpose and their responsibilities vis-à-vis the checklist. Upon completion of the forms comprising the Admission Package, the Social Workers submit the materials to the Front Desk who is responsible for forwarding the information to the FSU (via fax or courier). The Social Workers have no further involvement in the process and do not participate in the annual reviews. However, as mentioned above, the checklist is not clear as to the FSU requirements and the files reveal that different information is being received from the homes.

As mentioned in Recommendation 27, the forms utilized in each home are different which results in different practices within the resident files. We also noted that the files did not always contain the same information to support charges to the trust accounts. It was very difficult to trace the documents to the resident trust statements.

It is recommended that the FSU and the Branch establish the required documents to be provided to the FSU. During the transition, as the FSU performs transactions with respect to resident charges, that the staff review the files to ensure that each resident file contains the appropriate documents. One method to ensure that required documents are contained in the file is to create a checklist for staff in the homes to follow. Similarly, a file checklist could be created for the FSU to utilize to ensure that files are reviewed for completeness.

OAG: % complete *75%*

Management Representation of Status of Implementation of Recommendation 46 as of Winter 2011

Management agrees with the OAG’s follow-up finding, however, further progress has been made.

A process to ensure completeness of the resident financial files has been implemented. Detailed trust and accommodation statements incorporating all transactions during a resident’s stay in the home is placed in the resident’s file after discharge. Effective March 1, 2011 the FSU has been enclosing an Admission Checklist and Discharge Checklist in the resident’s file to ensure the resident file contains all appropriate documentation. On admission, the Social Worker is to provide the following documents to the FSU, with exception to residents in care of the Public Guardian and Trustee.

1. New Admission Information form
2. Signed Admission Agreement
3. Void cheque from the resident’s financial institution
4. Signed Payment Enrolment Authorized form
5. Signed Power of Attorney – Property (if applicable)

Thus, the requirements of the Social Worker to the FSU are clearly defined.

Management considers implementation of this recommendation to be complete.

Management: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 47 as of September 30, 2010

This recommendation requires resolution; it has therefore not been implemented.

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 policy and procedures were reviewed at staff meetings and were re-communicated to staff in May 2009 via email.

Management would be pleased to meet with the auditors undertaking the follow-up assessment in order to achieve resolution.

Management: % complete

0%

OAG's Follow-up Audit Findings regarding Recommendation 47

We are of the opinion that this recommendation is 75% complete.

The manager on call has access to the contact numbers for Corporate Security after hours to de-activate an access card. There is a well organized binder for required information about all four homes provided to the on-call manager; the schedule and process for the on-call manager are both well outlined. Although management disagreed with this recommendation, the follow-up revealed some issues which reinforces the need for enhanced procedures in this area. When verbal inquiries were made to registered staff in charge of the homes, they were not consistently aware of or familiar with the process for de-activation of access cards after hours nor did they indicate that they would initiate contact with the on-call manager to have the access card de-activated. Policy 750:14 "Access Cards - Staff, Volunteers, Students and Contractors", indicates that Corporate Security is e-mailed when a card has been lost and requires deactivation immediately. However, the policy does not address after-hour requirements for de-activation.

As well, we observed that different practices with respect to the issuance and monitoring of cards to families, visitors, students and contractors across the homes. There are varied methods used to track dates on which cards were issued and returned, replaced or de-activated. The policies and procedures 750:25 and 750:14

are confusing for staff and are not followed consistently across the homes. Definitions should be included and consistent. For example, contractors are addressed in both policies and therefore, one would have difficulty ascertaining which policy applies. Each home utilizes different forms (particularly for staff/volunteer/student cards). As well, in one home, the cards are labelled with special letters and tracked in this manner. For example, student cards are labelled with an "S" and contractor cards labelled with a "C". This allows for better management of the cards.

With respect to the cards to be picked up by families, they are simply stored in an envelope for pick up. There is no requirement to sign out these cards when received and therefore, the staff would be unaware that they were picked up other than the fact that it is not in the envelope. As well, there are no cardholder agreements that accompany the issuance of cards and the responsibilities of the cardholder to inform the home or Corporate Security of the card being lost or stolen. In the case of students, the forms do not track the expiry date of the cards nor the responsible manager.

In discussions with Corporate Security, threat risk assessments are planned for each home in order to ensure that the new legislative requirements are met to ensure a safe and secure home. It is recommended that, as part of this risk assessment, that detailed policies and procedures be developed. These should address the inconsistencies in reporting and ensure that all cards are accounted for and managed. We also understand that management of the Branch was intending to address these inconsistencies in an administrative meeting to be held in February 2011.

It is also recommended that cardholders are required to sign for the cards when received with associated rights and obligations. A charge associated with the replacement of the card should also be explored, particularly in cases where there are multiple instances of lost cards.

OAG: % complete *75%*

Management Representation of Status of Implementation of Recommendation 47 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The Threat and Risk Analysis for all Long Term Care Homes will be completed by the end of Q3 2011, and related policies and procedures will be reviewed by the end of Q4 2012.

Management: % complete *75%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 48 as of September 30, 2010

An access card process is in place in addition to an assessment process to determine resident capability. There is signage at the door to assist residents and a doorbell available that rings directly to the charge nurse in off-hours. Automatic door openers are also in place.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 48

We are of the opinion that this recommendation is 90% complete.

Access card policies and procedures are silent regarding access hours to the homes. Management indicated that access cards are generally issued for access from 8 a.m. to 8 p.m. with some modifications based upon resident capacity. There are no published guidelines or an indication in Policy 750:25 "Access Cards-Families and Residents" that a resident assessment of capacity is required prior to the issuance of the access card.

It was observed that there is a doorbell in place that rings to the charge nurse telephone after hours; the ability to open the door automatically is not consistent at all homes given the installation of "thumb locks" in a number of homes for additional security.

As mentioned in Recommendation 47, Corporate Security is undertaking a Threat and Risk Assessment of all of the homes in the near future in order to ensure legislative compliance. It is recommended that the issue of access to vestibules be addressed as part of the assessment.

OAG: % complete **90%**

Management Representation of Status of Implementation of Recommendation 48 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

Long Term Care and Corporate Security are undertaking a Threat and Risk Analysis for all of the Long Term Care Homes. This process is anticipated to be

complete by the end of Q3 2011 and will identify options for remedial action to address the vulnerabilities identified.

With the increased flexibility/affordability of the new Integrated Security Management System platform, there may be new viable options to address this concern. The Branch will consider related budgetary pressures during the development of the 2012 budget and if accommodated within the 2012 budget, will implement during that year.

Management: % complete *90%*

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.

2008 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).

Management Representation of the Status of Implementation of Recommendation 49 as of September 30, 2010

The policy and procedures were reviewed at staff meetings and were re-communicated to staff in May 2009 via email.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 49

We are of the opinion that this recommendation is 80% complete.

The policy 750:21 (new policy number) Security – Salespeople, Contractors, Trades people does not require specifically that vendors be accompanied by staff members. Further, there is another policy regarding contractors 750:14 which, we believe is meant to address situations where contractors are visiting the homes often or for a specific period of time. We noted different practices at the homes with respect to contractors. The contractor may be provided a card from the manager who is assigned the card or the contractor could be assigned a visitor card. Policy 750:14 indicates that contractors should get photo ID cards. After hours, if emergency services personnel or funeral homes require access to the homes, a staff member is assigned by the Charge Nurse to allow entry for these service providers. No access cards are provided.

It is recommended that the policies regarding contractors, vendors and trades people be reviewed and revamped with definitions including the procedures

depending upon the purpose and length of time that the vendor would be in the home. These policies and procedures should be separate from staff, volunteers and families as these are unique clients with different requirements depending upon the role of the vendor. The procedures for managing these cards should also be reviewed and revamped for consistency.

To address the original recommendation, Corporate Security should assess the risks at Peter D. Clark in the food service area as well as the parking spaces located in the loading area as part of its upcoming Threat and Risk Assessment.

OAG: % complete *80%*

Management Representation of Status of Implementation of Recommendation 49 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

Long Term Care and Corporate Security are undertaking a Threat and Risk Analysis for all of the Long Term Care Homes. This process is anticipated to be complete by the end of Q3 2011 and will identify options for remedial action to address the vulnerabilities identified. The Branch will consider related budgetary pressures during the development of the 2012 budget and if accommodated within the 2012 budget, will implement during that year.

Beyond the scope of the original recommendation, all LTC policies are reviewed on a formal schedule, on an ongoing basis. The OAG's suggestions have been noted.

Management: % complete *80%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 50 as of September 30, 2010

The health and safety terms of reference were reviewed and revised in March 2009 and re-communicated to the Joint Health and Safety Committee in May 2009.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 50

We are of the opinion that this recommendation is 75% complete.

We have reviewed the inspection schedule as well as the inspection results at each of the four homes. The inspection schedule is designed such that a part of the home is inspected each month with the entire home inspected once per year. We are of the opinion that this practice does not meet the provisions of Subsection 9(26) of the Occupational Health and Safety Act which states:

"Unless otherwise required by the regulations or by an order by an inspector, a member designated under subsection (23) shall inspect the physical condition of the workplace at least once a month"

Subsection 9(27) states:

"If it is not practical to inspect the workplace at least once a month, the member designated under subsection (23) shall inspect the physical condition of the workplace at least once a year inspecting at least a part of the workplace in each month."

The Guide to the Act published by the Ministry of Labour provides the following guidance:

"The workplace should be inspected at least once a month. In some cases, this may not be practical. For example, the workplace may be too large and complex to be inspected fully each month. In such a case, the committee should establish an inspection schedule that will ensure that at least part of the workplace is inspected each month and the entire workplace is inspected at least once a year".

There is a risk that a Ministry of Labour inspector could determine that the facility is non-compliant. Confirmation from the Ministry should be sought to ensure the current approach satisfies the stipulations for workplace inspections within the Occupational Health and Safety Act.

Beyond the scope of the original recommendation, we also noted the following:

- the inspection schedule includes workers that are not certified;
- Policy 900:02 does not address the requirement for a constructor or employer who receives written recommendations from a committee to respond in writing within twenty-one days;
- inspection forms were inconsistent from one month to the next; and,
- some inspection findings were considered "B-serious" but the actions taken were identified as "none" or "still in use".

OAG: % complete

75%

Management Representation of Status of Implementation of Recommendation 50 as of Winter 2011

Management agrees with the OAG's follow-up audit finding, however further progress has been made. A further review of the Terms of Reference for the Long Term Care Branch was undertaken and completed in February 2011 and as such the recommendation has now been fully implemented.

Beyond the original recommendation, the Branch, in cooperation with Occupational Health and Safety, has determined that from current findings of health and safety issues from monthly inspections there would be no value in expanding from a specified area inspection to a whole building inspection on a monthly basis. Finally, when a health and safety issue is identified in one home, the findings are shared and reminders are implemented at a branch level.

Management: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 51 as of September 30, 2010

This recommendation has not been implemented due to the reasons outlined in the management response.

Specifically, LTC remains actively involved with departmental planning. Following the LTC Branch accreditation award, the LTC Branch mission, vision, values and strategic directions were refreshed. This document was finalized in August 2010.

Management: % complete **0%**

OAG's Follow-up Audit Findings regarding Recommendation 51

Although, due to organizational changes since the original audit, this recommendation could not be addressed as presented, LTC has been actively involved in Service Excellence initiative where-by a strategic plan was developed and implemented, as well as the Executive Committee's strategic planning exercise. As such, the recommendation can be deemed to be fully implemented.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 52 as of September 30, 2010

Since Q4 2009 the LTC Branch has used a project charter process for Branch planning. This is accompanied by a project status reporting schedule to the Branch management team and is a standing item on monthly agendas.

Further, the FSU provides monthly reports to LTC managers which include detailed variance analysis.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 52

We are of the opinion that this recommendation is fully implemented.

The Branch has developed its mission, vision and strategic directions 2010-2013. Eleven priority strategies have been developed with quality improvement project charters facilitated by a member of the leadership team. The Branch has a work plan that is updated on a regular basis with regular updates through monthly Branch Management Team meetings. All managers understood the planning process as well as their role in the projects.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 53 as of September 30, 2010

Indicators were reviewed in the Fall of 2008. As part of the annual planning process, indicators will be reviewed to ensure relevance to industry practice.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 53

We are of the opinion that this recommendation is fully implemented.

The Branch is in the process of reconciling the indicators that are currently available to the long term care homes through RAI-MDS and the indicators that it traditionally collected to determine the most effective and meaningful indicators for the organizations to gauge their performance and determine quality initiatives. The balance scorecard indicators that the Branch utilized before the change to RAI-MDS (such as volunteer hours per resident, laundry utilization rates, food service costs per meal day) that have not been affected continue to be collected by the Branch. Managers are responsible for collecting the data and inputting the information in the data collection spreadsheets. These indicators are regularly reviewed at BMT meetings and serve as important comparators between months and homes.

OAG: % complete 100%

Recommendation 54

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 54 as of September 30, 2010

The last home (CAC) was implemented in September 2009. In Q4 2009, reports were developed and are accessible to managers.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 54

We are of the opinion that this recommendation is fully implemented.

Interviews with management clearly indicated that Telestaff has made reporting and analysis much simpler and accessible. Managers were able to access Telestaff reports and indicated that the reports provided more detail than was previously available in SAP. Managers also indicated that there were additional reports available but had not been fully explored. Therefore, there continues to be opportunities to improve reporting as the staff and management gain additional experience with the system.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 55 as of September 30, 2010

This recommendation requires resolution; it has therefore not been implemented.

Consistent with the Management Response above, there have been no issues with this approach.

Management would be pleased to meet with the auditors undertaking the follow-up assessment in order to achieve resolution.

Management: % complete

0%

OAG's Follow-up Audit Findings regarding Recommendation 55

We are of the opinion that this recommendation is fully implemented.

Although management disagreed with the recommendation, the risk assessment was completed as it was determined that there was no risk. Currently, managers are responsible for entering their program data into the balanced scorecard templates with an assigned oversight responsibility for the program. This approach appears to be working successfully for the homes. The Branch retains staff that

have specific expertise in the set up of the spreadsheets and assists managers where required.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 56 as of September 30, 2010

The shared services Service Level Agreements are scheduled for completion by the end of 2010. Finance will be undertaking a review of services in 2011 with anticipated completion by the end of Q3 2011.

Management: % complete

25%

OAG's Follow-up Audit Findings regarding Recommendation 56

We agree with management that this recommendation is 25% complete.

There have been many corporate changes with respect to RPAM and the FSU since the original audit. At the time of the audit, RPAM provided services on a geographic basis as opposed to a service basis. A corporate realignment resulted in the formation of the Public Works group which is now responsible for all long term care facilities. Further, Infrastructure Services is now responsible for life cycle costing and capital planning for the Branch. With respect to the FSU, at the time of the original audit the Financial Coordinator had two portfolios and was not able to concentrate solely on long term care. The FSU now has a dedicated Financial Coordinator for long term care who is able to better serve the Branch. The Branch has indicated that it is satisfied with the changes and that it is receiving improved corporate service.

Interviews with the FSU and Public Works indicate that service level agreements are in progress. However, it will likely be near the end of 2011 before complete. In

the interim, regular meetings between the Branch and the corporate resources appear to meet the requirements.

OAG: % complete *25%*

Management Representation of Status of Implementation of Recommendation 56 as of Winter 2011

Management agrees with the OAG's follow-up audit finding, however, further progress has been made.

This recommendation touches on four service areas: HR, Facilities Management, Life Cycle costing, and Finance.

Service Agreements with HR, Public Works, and Infrastructure Services were completed and signed in Q1 2011. It should be noted that the shared services departments and their clients will continue to meet and refine the agreements as they are living documents. For example, staff from the Long Term Care branch and staff from the Parks, Buildings and Grounds branch are continuing discussions and will be meeting to complete and finalize specifics relating to elevators and snow removal services at long term care homes. The Service Agreements include the list of services to be provided to the client and in some cases, their associated service standards. Although service standards have not been included in all Service Agreements, they have been compiled and submitted to ODP and will form the basis of performance measures to be developed in 2011 and 2012.

Finance is not a shared service department, and as such, was not part of the initiative described in the previous paragraph, but will be undertaking a review of services with anticipated completion by the end of Q2 2012.

Management considers implementation of this recommendation to be substantially complete.

Management: % complete *75%*

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.

2008 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*.

Management Representation of the Status of Implementation of Recommendation 57 as of September 30, 2010

Revised materials have been developed and will be included in the next Councillor orientation program. A new brochure on non-profit homes was also developed with OANHSS. Finalization of the program is scheduled for Q4 2010.

Management: % complete

75%

OAG's Follow-up Audit Findings regarding Recommendation 57

We are of the opinion that this recommendation is 25% complete.

The intent of the original recommendation was to underscore the importance of City Council's governance responsibilities under the *Long-Term Care Homes Act, 2007*, the *Occupational Health and Safety Act* and other governing legislation. In our opinion, the briefing notes specific to the LTCHA does not reference governance nor does it identify the expanded expectations for Boards of Management (e.g., City Council).

OANHSS recently held a webinar session regarding governance requirements under the LTCHA. It is suggested that the Branch provide an overview of the governance responsibilities to City Council, perhaps as part of the next strategic planning sessions.

OAG: % complete

25%

Management Representation of Status of Implementation of Recommendation 57 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The Branch will provide an overview of the governance responsibilities to City Council to underscore the importance of their governance responsibilities under the Long Term Care Homes Act, 2007 (Management notes the reference to the LTC Act in the original recommendation is an error as it is an existing piece of legislation that governs the Community Care Access Centres in Ontario), the Occupational Health and Safety Act and other governing legislation by the end of Q4 2011.

As the Councillor Orientation Manual will not be updated for another four years the overview will likely take the form of a report to Community and Protective Services Committee which will rise to Council.

Management: % complete

25%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 58 as of September 30, 2010

Policy and procedures have been revised and were implemented on November 20, 2009.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 58

We are of the opinion that this recommendation is 100% complete.

We reviewed the monthly report which lists performance appraisals due for the month. Evidence shows that these reports are being utilized by managers to track deadlines and ensure targets are met. Each performance review that we observed had a copy of the education and training that staff had attended over the past period. This served as a discussion point with the manager at the time of the performance appraisal. The process for communicating staff identified training needs at the time of the performance review continues to be refined at the homes between the managers and the Best Practices Coordinator.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 59 as of September 30, 2010

Regular monthly operating reports, including compensation costs, are provided by the FSU. To supplement the cost data, HR reports on 'hours by position' are provided when requested and training on how to run these reports has also been offered. Analysis of the hours and cost data is provided by the FSU thereby assisting managers to effectively manage their resources.

A review of the Personnel Cost Planning (PCP) tool by the Financial Management Information Systems group has been completed and has identified that the current configuration of the product does not allow for the type of reporting on gapping that is required. Finance has included a project for enhanced SAP reporting in their 2011 Service Excellence plan. This project will include a gapping report. Management expects to complete this recommendation by the end of Q4 2011.

Management: % complete *95%*

OAG's Follow-up Audit Findings regarding Recommendation 59

We agree with management that this recommendation is 95% complete.

Although the FSU indicated that it does not support or provide information from Telestaff, it does provide monthly reports that provide compensation information including hours worked by position as well as compensation costs. The Personal Cost Planning tool was designed to develop budgets but is not a tracking tool. The FSU provides managers with regular monthly operating reports, including compensation costs, and are able to access a variety of reports as managers become more proficient in the use of the Telestaff and SAP systems. The feedback from managers suggests that the Telestaff system is "user friendly" and that the reports to date are useful in assisting them to effectively manage their resources. It is suggested that reports continue to be analyzed to provide additional information to assist managers in analyzing salaries and wages as well as mandatory staffing requirements.

OAG: % complete *95%*

Management Representation of Status of Implementation of Recommendation 59 as of Winter 2011

Management agrees with the OAG's follow-up audit finding.

The status of implementation has not changed since that provided as at September 30, 2010.

Management expects to complete implementation of this recommendation by the end of Q4 2011.

Management: % complete *95%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 60 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 60

We are of the opinion that this recommendation is fully implemented.

We observed that the homes have quality management plans in place and undertake regular quality monitoring audits. The quality management program is documented in policy and procedure 700:34; this policy was revised in Q1 2009 which reflects the changes to the balanced scorecard program reporting process. According to management and as evidenced by agendas and minutes, the quality indicators and management plans are discussed regularly at BMT meetings.

OAG: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 61 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 61

We are of the opinion that this recommendation is fully implemented.

We reviewed the Quality Management Team Terms of Reference as well as a sample of agendas and minutes for 2009 and 2010. Quality indicators are regularly reviewed and annual work plans are established at these meetings. Policy 700:34 outlines the quality management program with a revision in Q1 2009 to reflect balanced scorecard program changes. The meetings are held monthly with a quarterly meeting with the Home Advisory Committee. The team also undertakes an annual review of its own performance and effectiveness.

OAG: % complete

100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 62 as of September 30, 2010

An annual efficiency template was developed in Q1 2009 and has been in use by all service areas since Q2 2009.

Management: % complete

100%

OAG's Follow-up Audit Findings regarding Recommendation 62

We are of the opinion that this recommendation is fully implemented.

The long term care homes and Branch management are actively involved in provincial and national associations. There are assigned representatives at identified community meetings to promote expertise and sharing of best practices across the sector. The homes seek to promote visibility at conferences with a

regular review of literature and journals. It is noted that the development and implementation of best practices has grown across the Branch, in large part through the revised role and responsibilities of the Best Practice Coordinators and their efforts as a Functional Team.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 63 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 63

We are of the opinion that this recommendation is fully implemented.

The Branch continues to expand its involvement in seniors' initiatives and is involved in many associations. Although the Branch was realigned after the original audit, the managers participate in initiatives such as Communities of Care. However, the Branch is also evaluating some of the existing partnerships with the view to focus on specific initiatives that are viewed as the most effective.

OAG: % complete **100%**

Recommendation 64

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 64 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 64

We are of the opinion that this recommendation is fully implemented.

We note that the job description for the Best Practice Coordinator has evolved to support development and training of staff, with a greater focus on the clinical requirements. The Best Practice Coordinators' Functional Team is responsible for ensuring that mandatory training reflects industry best practices. There has been a recognizable investment in the Best Practice Coordinator positions and their role. It appears that this change has had a positive impact with respect to the training curriculum.

OAG: % complete 100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 65 as of September 30, 2010

The social worker position was reviewed and job evaluation was completed in July 2010.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 65

We are of the opinion that this recommendation is fully implemented.

Management undertook a job evaluation of the social worker position, which resulted in a reduction in clerical tasks which were delegated to other staff or eliminated through technology. Thus, the new job description and social worker function concentrates on admission, counselling and duties as outlined.

OAG: % complete **100%**

Recommendation 66

That more cooperative purchasing be pursued across all homes.

2008 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.

Management Representation of the Status of Implementation of Recommendation 66 as of September 30, 2010

This recommendation has been implemented per the Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 66

We are of the opinion that this recommendation is fully implemented.

The Branch now has 21 standing offers for common services as well as Complete Purchasing contract. The Hospitality Managers also indicated that they are exploring other cooperative purchasing on an ongoing basis. For example, the managers undertook to review steamers as a possible cleaning approach. Since steamers may not be individually over the threshold, the managers saw benefit in analyze all options together with the view to have one supplier (if it was approved as an approach). It was clear to us that cooperative purchasing has become part of the operation rather than an afterthought.

OAG: % complete **100%**

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 67 as of September 30, 2010

This recommendation has been implemented per the Management Response above.

Management: % complete 100%

OAG's Follow-up Audit Findings regarding Recommendation 67

We are of the opinion that this recommendation is fully implemented.

We reviewed the project plans and charters for the Goldcare and Telestaff implementations. Both systems have been implemented and considered successful. There is a Resident Care Information Steering Committee that has identified goals and milestones for documentation enhancements now that RAI-MDS has been implemented. With respect to Telestaff, managers and staff are comfortable with the systems and can navigate effectively. With respect to both Goldcare and Telestaff, there continues to be a reliance on administrative staff for some reports. Managers indicated that they are aware that additional reports and functionality exist in the systems and over time, these will be explored. Overall, the implementation of the systems have resulted in staff savings with respect to time as well as improved acuity reporting. As indicated in Recommendation 22, the case mix index for all four homes has increased since the original audit which results in additional provincial funding.

OAG: % complete 100%

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 68 as of September 30, 2010

Assistance in analyzing and running ad hoc reports from SAP with data on hours and cost is currently being provided by the FSU when requested. The FSU has

received feedback from the client that the information currently provided is acceptable to allow them to effectively manage their resources.

A review of the Personnel Cost Planning (PCP) tool has been completed by the Financial Management Information Systems group and has identified that the current configuration of the product does not allow for the type of reporting on gapping that is required. Finance has included a project for enhanced SAP reporting in their 2011 Service Excellence plan. This project will include a gapping report. Management expects to complete this recommendation by the end of Q4 2011.

Management: % complete *95%*

OAG's Follow-up Audit Findings regarding Recommendation 68

We are of the opinion that this recommendation is fully implemented.

Although the FSU does not directly support Telestaff, they provide the Branch with regular reports outlining staffing hours and compensation costs. These together with the reports that managers have available from Telestaff provide managers with good tools to manage staffing requirements and monitor budgets. Managers indicated, in all homes, indicated that they have received training on analyzing and running reports from SAP with data on hours and cost. These reports are supported by reports available from Telestaff. The managers indicate that the information provided by the FSU assists them in effectively managing their resources.

OAG: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 69 as of September 30, 2010

This is current practice as per the Management Response above.

*Management: % complete**100%***OAG's Follow-up Audit Findings regarding Recommendation 69**

We are of the opinion that this recommendation is fully implemented.

The Branch has been responsive in its review of survey tools. Examples of such responsiveness include: change to the distribution of the admission survey from the time of admission to the scheduled care conference at 4-6 weeks post admission, thereby, providing clients some time to experience services and provide feedback on such. It is suggested that there may be an opportunity to reduce administration costs by better using available/accessible tools and technologies. We note that the homes receive Resident/Family survey results by care area which allows for quality initiatives specific to resident home areas. As indicated in Recommendation 30, we suggest that the survey questions with respect to the financial experience with the FSU be expanded.

*OAG: % complete**100%***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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 70 as of September 30, 2010

Finance has established a TCA policy for compliance. The Branch and FSU worked with Corporate Finance to assess the implications and determine the eligibility of assets. A Tangible Asset spreadsheet has been developed and implemented as per City of Ottawa protocol and is in place.

*Management: % complete**100%***OAG's Follow-up Audit Findings regarding Recommendation 70**

Although some minor action is still required, we are of the opinion that the recommendation is essentially 100% implemented.

We note that Finance has fully implemented the requirements to include tangible capital assets values on the balance sheet for the City. The Branch is well aware of their requirements to provide TCAs to Finance including acquisitions and disposals. The recommendation referred to the development of accrual based budgets to show the cost of providing services as they are delivered. That is,

matching of capital expenditures usage (amortization) against provision of service. This approach will allow for improved costing and fee development. We did not see evidence that this is occurring except at the City level.

OAG: % complete **100%**

Recommendation 71

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 71 as of September 30, 2010

The condition assessment for the Garry J. Armstrong Home has taken place and the result has been incorporated into the overall lifecycle renewal program.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 71

We are of the opinion that this recommendation is fully implemented.

Since the original audit, there have been some organizational changes within the City which resulted in Infrastructure Services becoming responsible for life cycle and long term capital planning. As well, Public Works provides preventative and reactive maintenance services through a work order system. In the development of the capital budget, the Branch has provided input regarding their concerns. Infrastructure Services has undertaken condition assessments of all of the homes and has developed a long term capital plan on this basis.

OAG: % complete **100%**

Recommendation 72

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 72 as of September 30, 2010

A Concept Value Case was submitted to IT to automate the inventory supply process within the four Long Term Care homes by moving to wireless bar coding technology for inventory tracking and stock distribution in order to achieve efficiencies. The LTC Branch has advised the FSU that the Bar Coding Inventory System submission was rejected, as no return on financial investment would be achieved based on the use of technology for food which is purchased and consumed on a weekly basis. In lieu of the Bar Coding Inventory System, further checks and balances were implemented in the Home to ensure protection of assets.

Management: % complete *100%*

OAG's Follow-up Audit Findings regarding Recommendation 72

We are of the opinion that this recommendation is fully complete.

As discussed in Recommendation 39, our recommendation refers to an inventory management system incorporating policies and procedures. Although, ideally, a technological solution provides additional controls, detailed policies and procedures are effective control mechanisms to ensure inventory is managed at the home level. We are aware of the inventory policies and procedures developed at the corporate level and recommend that they be incorporated into the practices of the homes.

OAG: % complete *100%*

Management Representation of Status of Implementation of Recommendation 72 as of Winter 2011

Management agrees with the OAG's follow-up audit.

The duties of the storekeeper have been segregated. An on-line ordering system is in place for food services and is completed by the Food Service Supervisor, not the storekeeper. An electronic medication ordering system is in place with the external pharmacy provider and government pharmacy items are ordered by fax through the Ministry of Health and Long Term Care.

Management: % complete *100%*

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.

2008 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.

Management Representation of the Status of Implementation of Recommendation 73 as of September 30, 2010

A review has been completed and recommended changes have been costed. Recommendations for changes were brought forward through the 2010 and 2011 budget processes (relates to Recommendation 2).

Management: % complete ***100%***

OAG's Follow-up Audit Findings regarding Recommendation 73

We are of the opinion that this recommendation is 100% complete.

We interviewed the Best Practice Coordinators who indicated that there is full recognition of the requirements for mandatory training under the Long-Term Care Homes Act, 2007. While each Coordinator stated a preference to repeat the successful 2010 program, they are aware that an alternate strategy will be required should the budget request not be approved. Within the Functional Team meetings, they have begun discussions on alternate formats and methods of reaching 100% of staff in each home. The recommendation pertaining to the exploration of successful mandatory programs in other homes remains relevant to this review. The Functional Team is encouraged to develop interactive electronic training tools that can be distributed to staff across all shifts and can generate pre and post learner evaluations.

OAG: % complete ***100%***

Recommendation 74

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

2008 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.

Management Representation of the Status of Implementation of Recommendation 74 as of September 30, 2010

A comprehensive manual was developed, posted on Ozone, and communicated to staff on November 27, 2008.

Management: % complete ***100%***

OAG's Follow-up Audit Findings regarding Recommendation 74

We are of the opinion that this recommendation is fully implemented.

We observed that the Best Practice Coordinators, within their Functional Team, have developed in-service programs that reflect evidence-based best practices. These in-service programs and training materials are available on Ozone. Best

Practice Coordinators each assume responsibility for the development of content and training materials. These items are reviewed and revised by the Functional Team. While training profiles for each in-service have not specifically been developed, there are minuted discussions that support the determination of training objectives, deliverables and expected outcomes. The programs developed to date comprise a comprehensive library of training resources for ongoing use across the Branch.

OAG: % complete **100%**

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.

2008 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

Management Representation of the Status of Implementation of Recommendation 75 as of September 30, 2010

This is current practice as per the Management Response above.

Management: % complete **100%**

OAG's Follow-up Audit Findings regarding Recommendation 75

We are of the opinion that this recommendation is 100% implemented.

We note that the Best Practice Coordinators' Functional Team is highly successful and effective in developing and implementing staff training programs for the four homes. The descriptions of the Functional Team depict a synergy and productivity that has standardized training programs across the Branch and aligned resources carefully.

OAG: % complete **100%**

4 SUMMARY OF THE LEVEL OF COMPLETION

1. The table below outlines our assessment of the level of completion of each recommendation as of February 16, 2011.

CATEGORY	% COMPLETE	RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	PERCENTAGE OF TOTAL RECOMMENDATIONS
LITTLE OR NO ACTION	0 – 24		-	-
ACTION INITIATED	25 – 49	27, 56, 57	3	4%
PARTIALLY COMPLETE	50 – 74	2, 39	2	3%
SUBSTANTIALLY COMPLETE	75 – 99	6, 17, 30, 43, 45, 46, 47, 48, 49, 50, 59	11	15%
COMPLETE	100	1, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 44, 51, 52, 53, 54, 55, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75	59	79%
TOTAL			75	100%

2. The table below outlines management’s assessment of the level of completion of each recommendation as of Winter 2011 in response to the OAG assessment. These assessments have not been audited.

CATEGORY	% COMPLETE	RECOMMENDATIONS	NUMBER OF RECOMMENDATIONS	PERCENTAGE OF TOTAL RECOMMENDATIONS
LITTLE OR NO ACTION	0 – 24	27	1	1%
ACTION INITIATED	25 – 49	-	-	-
PARTIALLY COMPLETE	50 – 74	39	1	1%
SUBSTANTIALLY COMPLETE	75 – 99	17, 47, 48, 49, 56, 57, 59	7	10%
COMPLETE	100	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 45, 46, 50, 51, 52, 53, 54, 55, 58, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75	66	88%
TOTAL			75	100%

5 CONCLUSION

In conclusion, we found that there has been significant effort over the past two years by the Branch to meet the recommendations contained in the original audit. The Branch has evolved significantly whereby the four homes work together for the overall benefit of residents. There is evidence of growth and evolution of the “Branch” model with standardization in practice and Functional Teams success. This can only be done with strong leadership, which we witnessed. For some recommendations, although there remains minor action to be completed, a rating of 100% complete has been given.

This has occurred in a time of significant change in the long term care sector. There are clear partnerships being formed between the Branch and the corporate services such as the FSU, Public Works, Corporate Health and Safety and Infrastructure Services. Further, implementation of systems and technologies supported by Information Technology Services and the vendor partners has improved efficiencies and effectiveness at the operational level. Managers and staff have embraced the changes and have supported their staff throughout the changes. This is not to say that there are no outstanding recommendations, such as trust management policies. However, management has indicated that these items are being addressed and evidence indicates that this is the case.

We witnessed a highly motivated group of professionals that share a common purpose and commitment to improvement and quality. The resident and family surveys clearly show that the service provided by the homes is excellent and continues to improve.

6 ACKNOWLEDGEMENT

We wish to express our appreciation for the cooperation and assistance afforded the audit team by management.