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PROVINCIAL UPDATE ON AUDITOR GENERAL RECOMMENDATIONS:
Department of Health and Wellness

Introduction

The **Department of Health and Wellness** (DHW) has 13 Auditor General chapters from April 2009 to November 2012 with a total of 218 recommendations. DHW has completed 52% of these recommendations. Of the 218 recommendations, 75 were from November 2012. This offered limited time to implement at the time of this report thereby impacting the Department's overall completion rate. If considering up to May 2012, DHW has 69% of its recommendations complete. DHW values the importance of the work of the Auditor General as a contributing factor to a more efficient and effective public sector and considers the implementation of the remaining recommendations a priority.

Recommendations by Chapter:

Month & Year	Chapter	Chapter Title	Complete	Work In Progress	Action No Longer Required	Do Not Intend To Implement	Total Recommendations
Apr-09	Chapter 2	Government-wide: Audit Committees	1	1	-	-	2
Jul-09	Chapter 1	Pandemic Preparedness	27	1	-	1	29
Feb-10	Chapter 2	Electronic Health Records	5	2	-	1	8
Jun-10	Chapter 4	Mental Health Services	12	7	-	-	19
Nov-10	Chapter 5	Government Financial Reporting	-	1	-	-	1
May-11	Chapter 4	Colchester Regional Hospital Replacement	10	1	1	-	12
May-11	Chapter 5	Long Term Care - New and Replacement Facilities	3	3	-	1	7
Nov-11	Chapter 4	Protection of Persons in Care	3	3	-	-	6
May-12	Chapter 3	Addiction Services at Annapolis Valley Health	5	7	-	1	13
May-12	Chapter 4	Infection Prevention and Control: Cape Breton and Capital Health	24	5	-	-	29
May-12	Chapter 5	Nova Scotia Prescription Monitoring Program	8	9	-	-	17
Nov-12	Chapter 3	Capital Health and IWK Health Centre Personal Health Information Systems	7	50	1	-	58
Nov-12	Chapter 4	Hospital System Capital Planning	9	8	-	-	17
		Total	**114**	**98**	**2**	**4**	**218**
		Percentage	52%	45%	1%	2%	100%

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Brief Summary of Recommendations:

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Apr-09	Chapter 2 (12)	Work in Progress	Work is underway to define scope and begin development of the policy. The Policy and Planning branch of DHW is incorporating input from Internal Audit (IA) and Finance on possible policy inclusions and best practices. Target for completion of this policy is end of fiscal year 2013-14.
Apr-09	Chapter 2 (13)	Complete	DHW requested DHAs/IWK assess their need for an internal audit function. Based on this assessment and an internal review, DHW's Deputy Minister (DM) and Department of Finance (DOF) Executive Director, Audit, determined DHW establish an audit function at DHW with specific assignment to DHAs/IWK. An Internal Audit (IA) section housed at DHW with a Director, Manager and one non-management full time equivalent (FTE) now exists. IA consulted with DHW's DM and Chief Financial Officer and DOF determining seven additional FTEs were required; five to be hired in 2012-13 and two to be hired in 2013-14.
Jul-09	Chapter 1 (2)	Complete	Workforce Development Framework and recruitment/retention/building capacity implemented. Medical Officer of Health (MOH) job description updated. Two regional MOHs hired and third has funded residency based on return of service agreement for 2013. Epidemiological position reclassified with competitive package to continually attract qualified applicants as required. Business continuity strategies in place. Dedicated Human Resources Consultant is active with ongoing recruitment efforts as required.
Jul-09	Chapter 1 (3)	Complete	Audit tool developed and used by DHAs/IWK in the completion of their Pandemic/All Hazards/Business Continuity Plans. Shortfalls within district emergency planning were identified and addressed. DHA/IWK plans complete. DHW continues to monitor status of DHAs/IWK regarding pandemic planning.
Jul-09	Chapter 1 (7)	Complete	Audit tool developed and used by DHAs/IWK in completion of their Pandemic/All Hazards/ Business Continuity Plans. Shortfalls within district emergency planning were identified, addressed and used to assess DHAs/IWK Business Continuity Plans monthly. Former Department of Health (DoH) and Health Promotion and Protection (HPP) submitted Business Continuity Plans to Emergency Management Office (EMO) June 2009. On an ongoing basis, DHW works with Departments of Agriculture and Environment to ensure that public health inspectors are trained with respect to their authority under the Health Protection Act and Memoranda of Understanding are reviewed and updated regularly to clarify roles regarding public health emergencies.
Jul-09	Chapter 1 (8)	Complete	Pictou County Health Authority (PCHA) Business Continuity Plan completed March 2009; revised April 2009. DHW will continue to work with DHAs/IWK regarding business continuity pandemic planning on an ongoing basis.
Jul-09	Chapter 1 (9)	Complete	All Hazards Risk Vulnerability Assessment Report was completed and approved the end of September 2012.

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Jul-09	Chapter 1 (10)	Complete	Key DHA pandemic planning issues identified via DoH/HPP/DHA collaboration and the newly developed audit tool. DHAs/IWK submitted Pandemic/All Hazards/Business Continuity Plans. DHW continues to monitor DHA/IWK plans regarding pandemic planning.
Jul-09	Chapter 1 (11)	Complete	The DHW All Hazards Leads is the mechanism for approval. This ensured that subject matter experts had input and that all parties understood their roles and responsibilities. The Health System All Hazards Plan was completed and approved in September 2012.
Jul-09	Chapter 1 (12)	Complete	In consort with DHAs/IWK, significant revision to the Health System All Hazards Plan was required as a result of H1N1 lessons learned. Changes included addressing clinical components to a communicable disease pandemic. The Health System All Hazards Plan was completed and approved in September 2012.
Jul-09	Chapter 1 (13)	Complete	Legal support played an integral role to this project participating at Pandemic Leads meetings. The plans were legally reviewed as part of approval process. With legal review prior to its finalization, the Health System All Hazards Plan was completed and approved in September 2012.
Jul-09	Chapter 1 (14)	Complete	During H1N1 authority for procurement of pandemic supplies was granted. Future supplies will depend on government approval.
Jul-09	Chapter 1 (15)	Complete	During H1N1 authority for procurement of pandemic supplies was granted. An adequate amount of supplies were procured as the supply level met the provincial needs. Future supplies will depend on government approval.
Jul-09	Chapter 1 (16)	Complete	Supply information required to complete analysis was provided as per direction from the then DM of Health and Wellness.
Jul-09	Chapter 1 (17)	Complete	During H1N1 authority for procurement of pandemic supplies was granted. Future supplies will depend on government approval. Remaining authority is subject to implementation of Supply Chain Management and Strategic Reserves Report.
Jul-09	Chapter 1 (18)	Complete	Process developed including a DHA request form to access provincial strategic reserves. 2009-10 Pandemic Influenza Plan includes process to access provincial and federal reserve supplies. DHA Emergency Managers updated biweekly and Chief Executiv eOfficers (CEOs) engaged in bi-weekly conference calls regarding strategic reserves.
Jul-09	Chapter 1 (19)	Complete	Provincial public health influenza surveillance system assessed through formal review and revision of the surveillance component of the provincial influenza program. This review included assessment and revision of key indicators and processes for tracking these indicators during influenza season. The revised surveillance component of the influenza program released in September 2011, identifies components of the influenza surveillance system and surveillance approach. Influenza surveillance is revised annually based on past influenza seasons and re-assessment of indicators is part of any pandemic program.

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Jul-09	Chapter 1 (20)	Work in Progress	Four provincial epidemiologist (epi) positions were created. Three of these four positions are currently filled (Epi 3 - 2 positions; Epi 2 - 1 position). The fourth position (Epi 1) is currently in competition process. This increased capacity will enhance DHW's ability to conduct public health epidemiological investigations during a pandemic.
Jul-09	Chapter 1 (21)	Complete	Provincial public health laboratory completed a capacity assessment for diagnosing pandemic influenza. Ten recommendations were made which forms the basis of a plan to address the identified gaps.
Jul-09	Chapter 1 (22)	Complete	Good Neighbour Protocol was signed by all parties allowing for a framework to deal with human resource issues during a pandemic.
Jul-09	Chapter 1 (23)	Complete	A set of Questions and Answers were issued as a result of joint meetings between unions and employers to prevent duplication of efforts regarding union issues in pandemic planning.
Jul-09	Chapter 1 (24)	Complete	Meetings of several government departments, DHAs, EMO and Nova Scotia Health Organizations' Protective Association determined that the Volunteer Services Act and Volunteer Protection Act are sufficient protection for volunteers. The existing health system process for engaging volunteers applies with all workers for compensation including during a pandemic. Volunteers outside the health care system are the responsibility of their respective organizations.
Jul-09	Chapter 1 (25)	Complete	A process for temporary licensing was established. Health Human Resources' guidelines are distributed to all parties as required.
Jul-09	Chapter 1 (26)	Do Not Intend to Implement	DHW completed significant work on this recommendation. Specific to H1N1 pandemic, Health Information Technology Services (HITS) developed the Intensive Care Unit (ICU) bed tracking system tested and complete. The scope of this recommendation was limited to pandemic preparedness. Over and above the recommendation, the Bed Utilization and Management Initiative was developed, approved, and is underway to help DHAs/IWK manage bed resources. The ability to identify ICU bed availability across the province on a timely basis will be available with the implementation of the "Bed Board" feature in Fall 2013.
Jul-09	Chapter 1 (27)	Complete	Audit tool to assess plans and protocols for standards for primary and secondary assessment centres were developed. During the H1N1 response all DHAs had primary and secondary centres open such that appropriate locations and plans were identified. Fifteen primary assessment centres were established all over Nova Scotia.
Jul-09	Chapter 1 (28)	Complete	Communications consultant was hired to review and update pandemic communications guidelines. Guidelines were further refined and completed by DHW Communications to include lessons learned from H1N1 and reflect the merger of HPP and DoH.

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Jul-09	Chapter 1 (29)	Complete	A consolidated list of health system stakeholders to receive DHW pandemic-related documents is complete and updated regularly. This group receives H1N1 bulletins through DHW's Health Services Emergency Management, when issued. Other government departments and agencies distribute DHW H1N1 information to their stakeholders. A contact list of communications staff of stakeholder organizations receive updates twice daily in times of increased H1N1 activity. Others receive communications materials when necessary. The Situation Room maintains a list of stakeholders directly involved in managing the H1N1 immunization program and is used to send timely advisories to front line staff.
Jul-09	Chapter 1 (30)	Complete	Priority groups to receive information identified including doctors, nurses, etc. and other government departments willing to distribute information to their stakeholders. Meetings held with other stakeholders including DHAs, universities, school boards, First Nations Chiefs, etc.. DHW also asked communications staff at stakeholder organizations to distribute information to further establish a broad distribution network.
Jul-09	Chapter 1 (31)	Complete	A lessons learned process is in place designed to address all emergencies from all hazards approach. A formal lessons learned process was developed and implemented as a result of the provincial H1N1 response.
Jul-09	Chapter 1 (32)	Complete	Process for finalizing lessons learned completed and incorporated into H1N1 work plans for working groups. Lessons learned will be ongoing. Work groups will review all issues to continually identify gaps.
Jul-09	Chapter 1 (33)	Complete	Process for lessons learned was completed and incorporated into H1N1. Lessons learned will be ongoing. Work groups will review all issues to continually identify gaps.
Feb-10	Chapter 2 (1)	Do Not Intend to Implement	With the speed at which technology is changing the landscape of eHealth, DHW determined a document of strategic direction is more realistic than a strategic plan. This document will describe goals and principles around the strategic direction Nova Scotia will take in rolling out future information technology and information management systems. The official document will cover 2013-18. DHW engaged in stakeholder consultation over the last 12 months to gather information for the Strategic Direction. In Fall 2012 relevant documents that would comprise the Strategic Direction were compiled and a draft report was received by HIO in April 2013. Other major components are currently being incorporated into the current draft. Vetting will continue including circulation with DHAs/IWK. However, funding will not be included in this document.
Feb-10	Chapter 2 (2)	Complete	All program areas within the continuum of health care are possible candidates for future inclusion in the Electronic Health Record (EHR). As data and information move from paper to electronic format they will be considered for inclusion into the EHR. The rate at which this happens will depend on funding made available to implement new ehealth solutions across the province. For each electronic solution that contains data, the appropriateness of that data being shared with the EHR will be taken into consideration. This is an ongoing process.

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Feb-10	Chapter 2 (3)	Work in Progress	DHW is participating in Atlantic iEHR Benefits Evaluation Project with the Atlantic provinces (excluding PEI) funded/sponsored by Canada Health Infoway. This project will develop a detailed timeline to obtain baseline data and identify how to monitor performance. Pre-evaluation surveys were completed. Newfoundland is targeted for re-engagement six months after the last data activation with a target of September 2013. The benefits evaluation analysis will be completed by the end of this fiscal year.
Feb-10	Chapter 2 (4)	Complete	DHW follows the Government Chief Information Office annual detailed instructions related to current and future Tangible Capital Asset (TCA) project requests. Within DHW all TCA submissions are reviewed by the Chief, Health Information Office, presented to Executive for prioritization and approval by the Deputy.
Feb-10	Chapter 2 (5)	Complete	DHW is following the documented Secure Health Access Record (NS EHR Project - SHARE) change control process. Further, a formal Change Control Board Committee has been established and meets regularly.
Feb-10	Chapter 2 (6)	Complete	Bill 89, An Act Respecting the Collection, Use, Disclosure and Retention of Personal Health Information (Personal Health Information Act – PHIA) is in effect as of June 1, 2013. Regulations were approved by Governor In Council with Schedule A including: definitions, designation of health care services, designation of prevailing provisions, collecting and using health card numbers, complaints, mediation, electronic Information systems, additional safeguards, record of user activity and fees for accessing personal health information records. Change management activities have been undertaken including: presentations to multiple audiences, dedicated website (www.novascotia.ca/dhw/phia) with toolkit and templates for custodians, fact sheets, FAQs, video and other materials for custodians and public, toll free inquiry line (1-855-640-4765 or 424-5419), and a dedicated e-mail (phia@gov.ns.ca).
Feb-10	Chapter 2 (7)	Work in Progress	There were 20 original risks identified in the privacy impact assessments and threat risk assessments. Of these, eight were addressed prior to December 2012, ten were completed as of March 2013. Two remain: vulnerability testing and patient communication. HITS-NS plans to finalize the vulnerability assessment plan by end of summer 2013. Brochures and posters are ready for the public launch of SHARE tentatively planned for Fall 2013.
Feb-10	Chapter 2 (8)	Complete	The 5970 Readiness assessment has been replaced with the Canadian Standard on Assurance Engagement (CSAE) 3416 which is the same but with additional requirements. The draft call-up for a firm to do a partial then full audit was completed. The type 1 (six month) audit was completed May 2012. Full type 2 audit is complete with a final May 2013 report .

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Jun-10	Chapter 4 (1)	Work in Progress	Standards with measures/indicators added and agreed upon by Provincial Mental Health Directors include: Promotion Prevention and Advocacy, Community Supports, Inpatient Standards, Outpatient Standards for Adult Services, Early Psychosis, Eating Disorder Standards. Standards with indicators await Provincial Mental Health Directors agreement include: Sexually Aggressive Youth, Youth Court Assessments, Forensic, Concurrent Disorders Systems Standards. New self-assessment process to measure compliance was reviewed with DHAs/IWK and is to be completed every three years, coinciding with DHAs/IWK accreditation process. DHW will make recommendations to increase compliance and document areas for improvement. Annual DHW follow up using shorter "Update Form" will ensure changes implemented or plan in place for implementation.
Jun-10	Chapter 4 (2)	Work in Progress	Appointed by the Minister, a 12 member Mental Health and Addictions Strategy Advisory Committee released its report, Come Together: Report and Recommendations of the Mental Health and Addictions Strategy Advisory Committee on April 23, 2012. The Minister accepted this report and results informed the development of a Mental Health and Addictions Strategy released in Spring 2012. $6.4 million of new money was committed to implement the strategy and standards.The implementation plan is complete and the budget established for implementation of the strategy recommendations, including those to ensure implementation of the standards. A One Year Status Report will be released in Summer 2013 that will outline the progress of the Strategy implementation.
Jun-10	Chapter 4 (3)	Work in Progress	DHW directed DHAs/IWK that evidence of assessment compliance ratings will be required to ensure adequate support for its assessment of compliance with mental health standards. Results of self-assessments will be reviewed through site visits to the DHAs/IWK.
Jun-10	Chapter 4 (4)	Work in Progress	New three year self-assessment developed and related self-assessment tool under development. This process will include completion of a self-assessment every three years to coincide with DHAs/IWK accreditation process. DHW will conduct site visits and produce an evaluation report making recommendations for improvement to increase compliance based on these self-assessments. An annual follow up using a shorter "Update Form" will ensure changes have been implemented or a plan is in place for implementation.
Jun-10	Chapter 4 (5)	Complete	A Provincial Concurrent Disorders Advisory Committee was established with membership comprising experts in mental health and addictions services. Committee developed draft Concurrent Disorder Standards which were reviewed by stakeholders and the provincial working group. Following approval by DHW's Policy Review Committee, standards await DM approval. The System Level Standards for Concurrent Disorders have been approved by the Deputy Minister and have been disseminated to Mental Health and Addiction Services in the DHAs/ IWK. A monitoring template and reporting requirements have been communicated as well.
Jun-10	Chapter 4 (6)	Complete	Most current standards (July 2009) posted to DHW website February 2010 with updates in June 2011 of standards that have been approved. In the future, any updated standards will be posted as reviews are completed and approved by the provincial Mental Health Directors and DHW as regular business.

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Jun-10	Chapter 4 (7)	Complete	Annapolis Valley Health Authority (AVHA), in addition to all other DHAs/IWK are recording the triage category.
Jun-10	Chapter 4 (8)	Work in Progress	Process for reviewing standards approved. Standards reviewed to ensure measurability and clarity include: Promotion Prevention and Advocacy Standards, Community Supports, Inpatient Standards, Outpatient Standards for Adult Services, Early Psychosis, and Eating Disorders. Standards reviewed, indicators added, and presented to the Provincial Mental Health Directors for agreement include: Sexually Aggressive Youth, Youth Court Assessments, Forensic. The System Level Standards for Concurrent Disorders have been approved by the Deputy Minister and have been disseminated to Mental Health and Addiction Services in the DHAs/IWK. A monitoring template and reporting requirements have been communicated as well.
Jun-10	Chapter 4 (9)	Work in Progress	Memorandum of Understanding (MOU) between Colchester East Hants (CEHHA) and Cumberland (CHA) has been signed, awaiting MOU between CEHHA and PCHA. MOUs will be monitored by DHW through the self-assessment process and site visits.
Jun-10	Chapter 4 (10)	Complete	DHAs/IWK now required to have formally documented future shared services agreements for mental health services submitted to DHW in the form of an MOU. MOUs between Capital Health and each of the DHAs for the Psychiatric Intensive Care Unit have been submitted. DHW will monitor service agreements through the self-assessment process and site visits.
Jun-10	Chapter 4 (11)	Complete	DM written directive sent to all DHAs/IWK that access to services must not be restricted. An Out of District Admission Protocol for out of district admissions or transfers was drafted by a working group of the Provincial Mental Health Planning Committee and approved by the Provincial Mental Health Planning Committee. Protocol will be monitored through the self-assessment process and site visits.
Jun-10	Chapter 4 (12)	Complete	A request was made to the DHAs/IWK to establish a formal policy for a process for youth to adult service transfer without service interruption. All DHAs have completed these policies. A formal policy and process between Capital Health and IWK was also developed to transfer patients between Child and Adult Services. Policies will be monitored by DHW through the self-assessment process and site visits.
Jun-10	Chapter 4 (13)	Complete	Mental Health Services websites for all DHAs/IWK are updated and DHW website updated to include DHAs/IWK links. Pictou, Cape Breton and Capital DHAs have forwarded to DHW copies of materials sent to clinics and physician offices. All other districts are using electronic formats and copying DHW on anything sent to clinics and physicians' offices. CHA's services are limited to the website.
Jun-10	Chapter 4 (14)	Complete	In response to DHW's request, DHAs/IWK developed and submitted current processes for formal communications with physicians within their catchment areas. Letters are sent out to physicians on a regular basis by DHAs/IWK as websites are updated or services changed. Copies of correspondence will be documented and the processes monitored by DHW.

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Jun-10	Chapter 4 (15)	Work in Progress	Process and guiding principles for the review of mental health data systems has been developed. Business requirements were reviewed and a common information system that will link with other DHA/IWK information systems was recommended. DHW is collaborating with DHAs/IWK to develop an electronic system for clinical use and planning and managing mental health and addiction services across the province. This common solution will provide better service and easier more consistent data analysis. Completion of the project enabled DHW to submit a Tangible Capital Asset (TCA) request for implementation of a common integrated solution. In May 2013, DHW submitted a TCA Proposal for fiscal year 2014-15 to implement a Mental Health and Addictions Services Solution.
Jun-10	Chapter 4 (16)	Complete	Data used include Management Information System and Discharge Abstract Data both using Canadian Institute for Health Information (CIHI) definitions and standards to enable interprovincial comparisons. Wait time reporting has been standardized through community wide scheduling. A general system data quality tool for community wide scheduling and registration is available to DHAs/IWK. DHAs/IWK users receive necessary training and technical support.
Jun-10	Chapter 4 (17)	Complete	Standardized provincial approach to reporting wait time information for mental health programs and services developed. Quarterly reporting has been established on a go-forward basis with Mental Health Outpatient Clinics/Community Mental Health chosen as a starting point for provincial reporting. DHW conducts a quarterly review of the report at mental health planning meetings as part of regular business. The need for provincial wait time information has been assessed and it was determined it can be tracked for outpatients. Whether this can or should be expanded to other patient groups may be revisited in the future as the Mental Health and Addictions Strategy is implemented.
Jun-10	Chapter 4 (18)	Complete	A standardized provincial approach to reporting wait time information for mental health programs and services was developed. Quarterly reporting using the mental health wait times audit report as the data quality audit tool for identifying data quality issues is being used for all DHAs/IWK.
Jun-10	Chapter 4 (19)	Complete	Capital Health reviewed its wait times information for accuracy. Improvements were implemented and an audit report demonstrated accuracy. Regular data quality audit reports will be produced to ensure accuracy of information.
Nov-10	Chapter 5 (8)	Work in Progress	A review of audits in their current manner shows that core risks are not being addressed, therefore, the audit engagements in their current format have been discontinued. Discussions are taking place with DHW's IA section requesting guidance and direction on what type of audit engagement should be undertaken and what areas to target to address the identified risks. It is anticipated that that a three to five year audit plan will be completed by Fall 2013 with the intent of having the first audit completed for the 2013-14 fiscal year end.
May-11	Chapter 4 (1)	Complete	Administrative process is now in place requiring completion of a schematic design including a Class C budget estimate to be completed prior to a submission to Cabinet seeking funding approval. The revised administrative process is reflected in the DHW Capital Spending Manual.

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May-11	Chapter 4 (2)	Complete	The energy model to evaluate operating costs of the physical structure is complete. CEHHA provided a request for potential expansions to be reviewed as part of the DHA business planning for 2012-13. Additional funding was provided for the operation of the new facility in the 2012-13 Business Plan.
May-11	Chapter 4 (3)	Complete	DHW has a comprehensive Submissions to Cabinet Policy in place which includes financial staff involvement as early as possible in the submission process to ensure submissions are accurate.
May-11	Chapter 4 (4)	Complete	Only one engineer was available for this project highlighting the need for more; now there are six. The manager challenges the design, budget and timeline of a project based on the Project Management Book of Knowledge. DHW implemented a process whereby program leads must sign off on schematics acknowledging to the design consultants that the plan is understood and agreed upon. This new process is reflected in the DHW Capital Spending Manual.
May-11	Chapter 4 (5)	Complete	DHW now requires the grossing factor to be clearly identified by the designer on all large new construction projects as well as regular review of grossing factors. This is reflected in the DHW Capital Spending Manual.
May-11	Chapter 4 (6)	Complete	Design decisions on all new projects will be evaluated with the view of standardization of design across all acute care facilities in the province. Design and specification standards are being developed for acute care, long term care, primary care and mental health facilities. The standard varies depending on the program type. DHW is involved at an earlier stage in the process and design criteria are challenged and evaluated across the province. Target completion dates are dependent on the program area as it has its own design and specification standards. This is reflected in the DHW Capital Spending Manual.
May-11	Chapter 4 (7)	Action No Longer Required	This project was approved and designed before the requirement for Leadership in Energy and Environmental Design (LEED) certification. Now LEED compliant facilities are the practice for new construction within all government departments.
May-11	Chapter 4 (8)	Complete	A process is now in place to address changes to contract documents during construction. This process is described in the Replacement Project Manual.
May-11	Chapter 4 (9)	Complete	DHW now only accepts Canadian Standards Association standards for area measurement on all future new construction projects. DHAs have been informed and this is reflected in the DHW Capital Spending Manual.
May-11	Chapter 4 (10)	Complete	Increased frequency of estimates by multiple sources will be used for future construction management projects of significant size. This is reflected in the DHW Capital Spending Manual.
May-11	Chapter 4 (11)	Complete	The contract with the Project Manager for the Colchester Regional Hospital replacement project was signed June 2012.

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May-11	Chapter 4 (13)	Work in Progress	The move into the completed Colchester Regional Hospital replacement was finished December 2012. A post occupancy assessment tool is being jointly developed by DHW and CEHHA. The tool should be ready for use in 12 to 18 months. The tool can only be applied 12 to 18 months after a project's completion.
May-11	Chapter 5 (1)	Complete	DHW's recommendations for the next round of replacement long term care (LTC) facilities/beds are based on a transparent, consistent process supported by documentation. Assessment criteria for existing LTC facilities and an evaluation tool to score the criteria were developed. There were site visits to 68 facilities built more than 15 years ago. Also, input was requested from other government departments and agencies, such as Office of the Fire Marshall. A team of DHW staff with different backgrounds and expertise participated in the evaluation.
May-11	Chapter 5 (2)	Complete	Each year as part of the operational plan development for the Continuing Care (CC) branch, progress towards achieving the goals and statuses of initiatives of the CC Strategy are reviewed and reprioritized. In 2012-13 government provided an additional $22 million for new and expanded home care initiatives. Pieces of work from the Strategy were considered in developing the priorities for this new money. Ultimately government approved 19 new initiatives, some from the Strategy, others that were not contemplated when the Strategy was conceived. Focus has shifted from the Strategy, which is now in its seventh year, to a focus on home and community care initiatives as much of the work to date under the Strategy focused on building new long term care beds. CC branch is working on a new plan to meet current and future demand and therefore the review of the CC Strategy has been completed.
May-11	Chapter 5 (3)	Complete	DHW and DHAs/IWK signed an MOU and developed an accountability framework which sets out roles, responsibilities, and authorities for LTC in Nova Scotia. DHW supported DHAs in their service agreement negotiations with LTC facilities. As of April 2012, all licensed LTC facilities have signed service agreements with DHW or a DHA.
May-11	Chapter 5 (4)	Work in Progress	DHW is dedicated to developing a risk assessment process for projects and to include this in their charters. The process will be applied to any subsequent projects before their launch. A position has been dedicated to this task as well as ensuring homes under construction follow through to completion.
May-11	Chapter 5 (5)	Do Not Intend to Implement	DHW developed a plan to include wait list information concerning LTC placement on its website. At this time, DHW has decided against posting specific (estimated) wait times/lists by facility: 1) as estimates are problematic to determine; and 2) current practice of public's precautionery applications for LTC assessment and "deferrals" of placement when offered, has resulted in wait lists and wait times that do not match reality. After the LTC placement policy is revised and home/community support is fully maximized, DHW will reconsider the inclusion of wait list information on its website. In the meantime, DHW will develop and post a fact sheet on its website which will explain aspects of the wait list and placement policy (for fact sheet: estimated completion date October 2013).

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May-11	Chapter 5 (6)	Work in Progress	DHW reviewed and updated the status of June 2007 Chapter 4 Auditor General recommendations. Currently three of the eight recommendations are complete (4.1, 4.3, 4.8). Recommendation 4.5 is related to the Homes for Special Care Act and is addressed in recommendation 5.7. Recommendation 4.6 is a "Work in Progress" with an expected completion of December 2013.
May-11	Chapter 5 (7)	Work in Progress	DHW has recently committed to developing CC legislation which will replace the existing *Homes for Special Care Act* , *Homemakers Services Act* and *Coordinated Home Care Act* , while incorporating other community-based options. Research on legislative options is underway. Discussions are occurring with Department of Community Services (DCS) to determine its level of involvement in the above process. At this point, the plan only includes new legislation, with regulations to follow.
Nov-11	Chapter 4 (1)	Work in Progress	In collaboration with DCS, the draft version of the Protection for Persons in Care Policy Manual has been completed. With appropriate approvals from both departments, the end product will be two slightly different manuals due to differing departmental practices and procedures. After review and recommended approval by DHW CC leadership, the manual will be reviewed by DHW's Policy Review Committee. Upon final approval, the anticipated release of the manual is expected September 2013. Upon release, it will be communicated to department staff, health care providers and other stakeholders.
Nov-11	Chapter 4 (2)	Work in Progress	DHW and DCS have had discussions on possible recommendations, timelines and assignments to address a complaints tracking system. Discussions have begun with DHAs to develop the best process for tracking complaints and a timeline for implementation. With the primary focus on the completion of the policy manual and work related to performance indicators, it is anticipated that a tracking process will be complete and in place by end of 2013.
Nov-11	Chapter 4 (3)	Work in Progress	DHW worked with DCS in the development of the Protection for Persons in Care Policy Manual. The revised manual incorporates all current and planned practices.The manual is proceeding forward for recommended approval by CC Leadership team followed by a review by the Policy Review Committee then final sign off. The current quality assurance file review checklist is in the midst of being updated to reflect current policies and practices. This will be implemented once the Protection of Persons in Care Policy Manual is approved.
Nov-11	Chapter 4 (5)	Complete	In June 2011 DHW implemented a quality assurance program to ensure files are appropriately documented and legislative requirements are addressed. File reviews are complete and a file audit checklist has been implemented. The manager must now sign off on all investigation reports.
Nov-11	Chapter 4 (6)	Complete	DHW has implemented processes to ensure that data recorded in the system is accurate and complete. The Manager of Investigation and Compliance reviews the database regularly and runs inquiry, investigation and file closure reports. Incomplete information is flagged for Investigating Monitoring and Evaluation Officers. Copies are maintained.

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Nov-11	Chapter 4 (9)	Complete	Process implemented for tracking facilities that have received training and information on the *Protection of Persons in Care Act* . Manager tracks all education, presentations, resource mail outs and maintains record of these communications and trainings.
May-12	Chapter 3 (1)	Work in Progress	In May 2013, DHW submitted a TCA proposal for fiscal year 2014-15 to implement a Mental Health and Addictions Services Solution. A Quality Framework for Addiction Services was completed November 2012 and will serve as a resource for the planning and implementation of quality activities, including monitoring of addiction services in DHAs/IWK.
May-12	Chapter 3 (2)	Work in Progress	New and revised standards state the standards are mandatory for all DHAs/IWK. DHW communicated this to DHAs/IWK when the standards for concurrent disorders were published in March 2013. Standards for prevention and health promotion and community-based services will be published in 2013.
May-12	Chapter 3 (3)	Work in Progress	Concurrent Disorders Standards and Community-Based Addiction Services Standards were worded to make measurement possible. Enhancements were made to the client information system (ASsist) to expand reporting capacity. Work commenced October 2012 to revise standards for Withdrawal Management and Structured Treatment. All revised standards will be measurable where possible.
May-12	Chapter 3 (4)	Work in Progress	When new and revised standards are approved, DHW will confirm in writing to DHAs/IWK that all standards must be measured and data collected, where possible. Further clarity will be provided through monitoring reports that accompany the launch of all new and revised standards. Mental Health and Addiction Services Solution-Strategy/Planning Project will establish requirements for a new information system which will assist DHAs/IWK in collecting the data needed to measure standards. In May 2013, DHW submitted a TCA proposal for fiscal year 2014-15 to implement a Mental Health & Addictions Services Solution.
May-12	Chapter 3 (5)	Work in Progress	New and revised standards will address the entire population seeking services. Standards for concurrent disorders were published in March 2013. Standards for prevention and health promotion and community-based services will be published in 2013.
May-12	Chapter 3 (6)	Complete	Changes to the wait time query were made to the client information system (ASsist) June 2012 to ensure accuracy of wait time calculations.
May-12	Chapter 3 (7)	Complete	The ASsist Administrator works systematically and collaboratively with DHAs/IWK quality management and research and statistical staff to ensure data quality. Every quarter Quality staff examine the ASsist data for quality assurance and to determine the information has been properly reported.

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May-12	Chapter 3 (8)	Do Not Intend to Implement	This was not identified as an issue with DHW and DHAs/IWK. Intake for withdrawal management services can currently be viewed across the province. DHW is reviewing and updating standards for withdrawal management and will examine standards related to accessibility, wait lists, and wait times. The Mental Health and Addiction Services Solution - Strategy/Planning Project will establish requirements for a new information system which will assist DHAs/IWK in collecting data needed for withdrawal management programs. Further analysis is required to determine the merits of a single province-wide intake and wait list for withdrawal management programs. In May 2013, DHW submitted a TCA proposal for fiscal year 2014-15 to implement a Mental Health and Addictions Services Solution.
May-12	Chapter 3 (9)	Work in Progress	Annapolis Valley Health Authority (AVHA) hired a community planner to link results of a needs assessment survey to the addiction services it delivers. AVHA participated in two provincial needs-based planning workshops hosted by DHW. AVHA initiated a community-based Opiate Issues Council to engage community leaders and monitor trends and needs of the community.
May-12	Chapter 3 (10)	Complete	File checklists are in place in AVHA as part of the new file management guidelines. AVHA hired a Quality Management Coordinator for Mental Health and Addictions Program which will assist in quality assurance processes and adherence to Accreditation Canada's quality dimensions.
May-12	Chapter 3 (11)	Complete	AVHA formed a Mental Health and Addiction Services Quality Team and developed a framework for file management and audit procedures in 2012-13. AVHA has initiated annual chart audits in identified program areas. A chart audit of the Opiate Replacement Treatment Program in AVHA was completed in 2012.
May-12	Chapter 3 (12)	Complete	The Mental Health and Addiction Services Quality Team in AVH has developed a framework, which will ensure improvements identified through chart audits are implemented.
May-12	Chapter 3 (13)	Work in Progress	Mental Health and Addiction Services Quality Team is developing a framework for outcome monitoring. DHW will support AVHA in the implementation of outcome monitoring as part of a provincial evaluation of the Labour Market Agreement for Persons with Disabilities. Implementation of the evaluation will be in 2013-14.
May-12	Chapter 4 (1)	Complete	Through the utilization of the Canadian Patient Safety Institute's Patient Safety Metrics measurement tool, DHW has initiated the provincial surveillance system. Currently, DHW has begun provincial surveillance of hand hygiene adherence rates and surveillance data for healthcare-associated Clostridium difficile (C. difficile) infections. The first submitted data sets are for the reporting period of January-March 2013. Quarterly data will be collected and evaluated at DHW and reported publically on the DHW website. Additional surveillance items will be included in a phased approach and DHW will take a regulatory approach to the reporting of these additional surveillance items under the *Patient Safety Act* .

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May-12	Chapter 4 (2)	Complete	DHW reviewed internal resource options to leverage employee skill sets to enhance the resource capacity within Infection Prevention and Control Nova Scotia (IPCNS). Branch commitments have been reprioritized to align with current resource capacity. Resource needs will be evaluated on an ongoing basis as increased data analysis needs are identified.
May-12	Chapter 4 (3)	Complete	The Deputy Minister has articulated the authority and responsibility of the IPCNS team to monitor and provide oversight. To this end IPCNS has implemented a series of initiatives and policies to ensure robust monitoring, measuring, and oversight processes are in place including regulations under the *Patient Safety Act* for monitoring hand hygiene adherence rates, healthcare-associated C. difficile infection rates, C. difficile managemenent guidelines and policy, and the safe surgical checklist policy. Additionally, a policy options paper was submitted to the Deputy Minister regarding certification of medical device reprocessing technicians. IPCNS has been given the mandate to provincially standardize the training and certification of these healthcare workers.
May-12	Chapter 4 (4)	Complete	Cape Breton District Health Authority (CBDHA) hired and orientated four new Infection Control Practitioners (ICPs). The Infection Prevention and Control (IPAC) team makes regularly scheduled visits to their assigned areas of responsibility in CBDHA.
May-12	Chapter 4 (5)	Complete	CBDHA completed its first report on the first C. difficile outbreak. As part of CBDHA's review, consideration was given to the validation of case related data to ensure that the final report is an accurate district representation of the first outbreak. Following great review, CBDHA concluded there was no second outbreak.
May-12	Chapter 4 (6)	Complete	Since January 2012, outbreak reports have been completed internally for all declared outbreaks and is now part of regular business.
May-12	Chapter 4 (7)	Work in Progress	There is ongoing planning to establish a formal reporting process through the Public Health Canadian Integrated Outbreak Surveillance Centre (CIOSC) alert system for reporting of outbreaks in acute care facilities. Additionally, DHW is exploring several options to increase the level of reporting from DHAs/ IWK to DHW.
May-12	Chapter 4 (8)	Work in Progress	CBDHA has been addressing recommendations in the IPCNS Report on the C. difficile outbreak with regular progress reports posted on its website. Thirty of the thirty-seven recommendations have been fully addressed. Work continues on the remaining seven recommendations.
May-12	Chapter 4 (9)	Work in Progress	All spray wands have been decommissioned in Capital Health with the exception of Dartmouth General Hospital. Renovations to the Dartmouth General Hospital are required to ensure compliance with the human waste disposal program. Related funding has been requested and completion of this recommendation is dependent on funding.

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May-12	Chapter 4 (10)	Complete	Capital Health has cited all recognized evidence based sources in all new and revised policies. All new policies/procedures from CBDHA contain evidence based references and any review or revision of existing policies and procedures includes reference to evidence based practices.
May-12	Chapter 4 (11)	Complete	Capital Health's Infection Control Department tracks its own development of policies and reviews timelines to ensure policies are reviewed regularly. Unless there are substantial changes to best practice standards or legislation, policies are updated every 3 years. For CBDHA, as of September 2012, there are no outdated IPAC policies and procedures. Its review and revision schedule ensures policies/procedures are reviewed and updated as necessary at least every three years and more often if new evidence becomes available.
May-12	Chapter 4 (12)	Complete	Cape Breton's IPAC team meets with Environmental Services every third Tuesday of the month. IPAC meets with Engineering Services every third Thursday of the month. These meetings are to discuss and resolve issues. The New Product Evaluation Committee has a representative from IPAC. The Manager responsible for IPAC is a member of the Quality and Patient Safety Committee.
May-12	Chapter 4 (13)	Complete	Capital Health established an Endoscopy Reprocessing Quality Improvement Group. A formal audit process for evaluating endoscope reprocessing documentation was developed. The policy entitled " IC 07-025 Flexible Endoscope Reprocessing - Documentation Requirements" was posted to the Capital Health website November 2012. It has been implemented along with a formal auditing process to ensure it is being followed. Results are discussed with the Endoscopy Reprocessing Quality Improvement Group, District Infection Control Committee, and Distric Medial Advisory Committee (DMAC) on Quality. Regarding CBDHA, its implementation of the new policies and procedures for scope clearning has resulted in 100% compliance with the requirement to produce evidence of scope cleaning.
May-12	Chapter 4 (14)	Work in Progress	Capital Health established a multi-disciplinary Reprocessing Committee to standardize processes to ensure equipment is reprocessed using Canadian Standards Association standards and best practice guidelines. This committee meets monthly and is finalizing its Terms of Reference. It has collaborated with Merged Services regarding language for Requests for Proposal (RFP) to ensure reprocessing information is provided by the vendor. Currently, strong processes are in place for any new items entering the Sterile Processing Department (SPD) to ensure reprocessing guidelines are provided or the item is declined for reprocessing (Work in Progress). CBDHA has developed Standard Operating Procedures Manuals that include manufacturer's instructions for reprocessing for all existing equipment and for new equipment as procured at all sites. (Complete).
May-12	Chapter 4 (15)	Complete	The Flash Sterilization Policy for Capital Health is complete.

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May-12	Chapter 4 (16)	Complete	Capital Health has reduced flash sterilization by: purchasing more equipment, transferring equipment among hospitals, increasing availability of single wrapped equipment, adjusting operating room (OR) booking, applying its process to ensure flash sterilization is used only in acceptable situations based on best practice guidelines. There is a process to audit and action each situation where flash sterilization is used. Audits of flash records are done daily and monthly. The Flash Sterilization Policy for Capital Health is complete. Over the past 2-3 years improvements have resulted in reduction in frequency of flashing. In CBDHA, every OR with a flash sterilizer has a flash log book. Every time flash sterilization occurs, it is recorded in the Adverse Events Monitoring System report and a form completed for review by the Flash Committee and OR management team. Evidence to support the effectiveness of this increased vigilance is the reduction of items flashed from an average of 7 per month in March/April 2012 to an average 1.5 per months since. Addressing the lack of instrumentation also reduced flashing.
May-12	Chapter 4 (17)	Complete	An IPC nurse was assigned to the completion of audits for all sterile processing units in CBDHA. Audits were complete September 2012. Repeat and regular audits to evaluate progress and opportunities for improvement will be scheduled according to degree of urgency and risk.
May-12	Chapter 4 (18)	Complete	Capital Health reviewed its sterile processing position descriptions and the related education requirements were verified as accurate.
May-12	Chapter 4 (19)	Complete	Capital Health has annual competency assessments completed by all Sterile Processing Department (SPD) staff (with the exception of those on leave). This is tracked on a monthly basis.
May-12	Chapter 4 (20)	Complete	The CBDHA yearly competency checklist implemented for all district SPD staff was completed by September 2012.
May-12	Chapter 4 (21)	Complete	Regular education sessions by manufacturers' representatives and/or the SPD team leader and supervisor have been implemented and documented.
May-12	Chapter 4 (22)	Work in Progress	Two provincial policies will be drafted to include both reprocessing of single-use medical devices as well as flash sterilization of surgical instruments. Resource challenges have necessitated deferring this work, however, these two policies will be completed in this fiscal year and no further delays are anticipated.
May-12	Chapter 4 (23)	Complete	Regarding CBDHA, hand hygiene audits are conducted routinely on most sites except rural hospitals. An ICP will be assigned routine auditing for three rural sites. As of October 19, 2012, 355 audits were completed in this fiscal year for a total of 6784 indications observed. The IPAC team is continuing to refine and develop the auditing and reporting process before sharing this responsibility with other health care providers.
May-12	Chapter 4 (24)	Complete	All IPAC staff are assigned to designated areas and facilities therefore both regular and random auditing occurs on a regular basis. Some long term care units and all rural facilites are included in the auditing process and included in the IPAC database.

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May-12	Chapter 4 (25)	Complete	In CBDHA, the new hand hygiene database provides for reporting in a myriad of ways. Of particular interest is the capacity to report compliance by health care provider which enables targeted education and improvement initiatives.
May-12	Chapter 4 (26)	Complete	In CBDHA, hand hygiene audit results are posted and updated with new averaged results on a monthly basis in most nursing units.
May-12	Chapter 4 (27)	Complete	Case definitions have been revised and approved by the Infection Control Committee for C. difficile, MRSA and VRE and are consistent with Canadian Nosocomial Infection Surveillance Program. All lab confirmed cases are reviewed against the appropriate case definition and a classification is assigned to each case.
May-12	Chapter 4 (28)	Complete	A completed and documented review of the surveillance program was included within the CBDHA program elements. The electronic component for surveillance for all reportable antibiotic resistant organisms is complete. General surveillance is also being done for surgical site infections, central line infections and ventilator associated pneumonia .The trending for surgical site infections is under review for improvements. The surveillance program is complete as of June 2013.
May-12	Chapter 4 (29)	Complete	Hospital acquired infection (HAI) rates are posted monthly on the CBDHA web page for the public and on the CBDHA IPAC Department intranet page for staff. Hand hygiene rates are posted on nursing units and in Fall 2012, HAI rates will also be posted on nursing units in a location that is accessible both to patients and families and staff.
May-12	Chapter 5 (1)	Work in Progress	DHW is collaborating with the Nova Scotia Prescription Monitoring Program (NSPMP) Board ("the Board") and Medavie Blue Cross ("the Administrator") to review and update the Service Level Agreement. Changes to date include: correction of error in frequency of pharmacy audits (stated as once a year, should have been once every two years), completion of a revised Complaints Policy and draft revised Service Level Agreement.
May-12	Chapter 5 (2)	Work in Progress	DHW representatives have met with Executive Director, Acute and Tertiary Care to discuss this issue. DHW representative is collaborating with the Administrator to gather information from all Nova Scotia hospitals regarding their policies and procedures related to the provision of monitored drugs to discharged patients.
May-12	Chapter 5 (3)	Work in Progress	In 2013, the provincial Drug Information System (DIS) will begin to assume the prescription capture functions for the Program to monitor and assess pharmacy actions based on response codes. In the meantime, the Administrator will develop an action plan to identify interim options to monitor and assess actions taken on response codes sent to pharmacies.

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May-12	Chapter 5 (4)	Work in Progress	The Board has determined that defining "effectiveness" as part of this recommendation is its responsibility. Upon its definition, the Board will collaborate with the Administrator to identify, develop and implement measurable indicators of effectiveness of alerts to become part of ongoing quality assurance.
May-12	Chapter 5 (5)	Complete	In 2013, DIS will assume the prescription capture functions for the Program thereby addressing this recommendation. In the interim, the Administrator has completed a policy regarding timely submission of prescription data to NSPMP. The new policy was approved. Official communication of the new policy was sent by fax to all pharmacies and included in the NSPMP newsletter in September 2012. With official communication to pharmacies/pharmacists, the policy came into effect.
May-12	Chapter 5 (6)	Complete	The current two year pharmacy audit cycle ensures that all pharmacies registered with the NSPMP are audited at least once every two years.
May-12	Chapter 5 (7)	Complete	The Administrator met with the College of Pharmacists of Nova Scotia in September 2012 to develop a re-designed audit process. This revised process and policy was approved by the Board in December 2012, and became effective immediately upon Board approval.
May-12	Chapter 5 (8)	Work in Progress	A committee was formed to redesign the PMP drug utilization review (DUR) framework and processes to reduce manual review. This Committee has met three times and has reviewed new technologies, internationally established evidence and validated indicators to form the new DUR framework. Based on this information a screening algorithm is under development.
May-12	Chapter 5 (9)	Work in Progress	With the process identified in 5.8 to develop a new DUR framework and noting the inclusion of a quality assurance process to review the adequacy and appropriateness of the work completed by staff on the DUR process, this will also satisfy recommendation 5.9.
May-12	Chapter 5 (10)	Work in Progress	As part of the development of the new DUR framework, a quality assurance program has been introduced. This includes staff conducting current DUR activities with senior staff auditing the related activities. Actions related to this recommendation are linked with the complete review and revision of the DUR framework noted in recommendations 5.8 and 5.9.

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May-12	Chapter 5 (11)	Work in Progress	As part of the DUR process, a policy is under development outlining expected timeframes for referral to a medical consultant based on different priority levels of cases. A quality assurance process will be incorporated to ensure timelines are followed. The following measures have been developed: a three-level priority system has been drafted and is currently being piloted; the medical consultant has offsite access through a secure portal to facilitate case follow-up. The following measures are under development: a new system for booking appointments with the medical consultant; and a revised format for case-reports.
May-12	Chapter 5 (12)	Complete	The process for generating the methadone monitoring report has been revised so the report now includes all prescriptions for monitored drugs, including methadone.
May-12	Chapter 5 (13)	Complete	The redesigned process for generating the methadone monitoring report now includes quality assurance checks to ensure reports are accurate and complete.
May-12	Chapter 5 (14)	Complete	The redesigned process for generating the methadone monitoring report includes quality assurance checks to ensure the reports, including patient agreements, are accurate and complete. This allows for accuracy and timeliness in the creation and delivery of notification letters to prescribers regarding patient noncompliance.
May-12	Chapter 5 (15)	Complete	With the implementation of DIS, duplicate prescription pads will no longer be used. In the interim, the process for managing duplicate pads has been revised. The revised documented procedures include steps regarding the immediate cancellation of lost, stolen or forged prescription pads. In addition, any time notification regarding a lost, stolen or forged pad is received, Administrator senior staff are notified, which prompts a quality assurance check to ensure that pad cancellation is complete.
May-12	Chapter 5 (16)	Complete	With the implementation of the DIS, duplicate prescription pads will no longer be used. In the interim, documented procedures have been revised to include steps to ensure that prescribers leaving the Program can demonstrate a need for additional duplicate pads. This process is completed by conducting a check of the prescriber's profile to verify that there is no documented 'termination date' or future-dated 'termination date' of the PMP coverage on file, and by reviewing the prescriber's existing inventory of prescription pads. If a prescriber is leaving the Program, and is going to be provided additional pads, the process includes documenting, on the prescriber's file, that a discussion regarding the need for additional pads has taken place, and that it was deemed appropriate to provide additional pads, based on that discussion.
May-12	Chapter 5 (17)	Work in Progress	DHW is collaborating with the Board and Administrator to determine the most efficient and cost-effective approach to implement all of the recommendations.

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Nov-12	Chapter 3(1)	Work in Progress	Regarding Capital Health, documentation in development for use of application, access, and protection/recovery of identified system data. The review of documentation began May 2013.
Nov-12	Chapter 3(2)	Work in Progress	Capital Health is currently developing an evaluation matrix to inform system prioritization which will be sent to the Information Management Evaluation Committee (IMEC) for review and approval. Capital Health has drafted an evaluation matrix for scoring and ranking systems for disaster recovery (DR). The tool will be used to engage departments and clinical service areas to conduct the prioritization of systems for recovery. The criteria for ranking include patient safety, business impact and users affected. Upon completion and approval of the matrix, applications will processed, scored and evaluated with stakeholders to arrive at consensus.
Nov-12	Chapter 3(3)	Work in Progress	The application evaluation matrix currently under review at Capital Health will be used to inform testing and training strategies as it relates to DR. In accordance with the AG recommendation, a test and training plan will be derived and scheduled for significant processes based on the new ranking.
Nov-12	Chapter 3(4)	Work in Progress	The procurement process is continuing with the provincial preparation of the Request for Proposal (RFP) for the Alternate DataCentre (D2). RFP review, approval and release is expected in six to eight weeks. Capital Health planning for Data Centre 1/Data Centre 2 locating of systems to be incorporated in system upgrade/lifecycle management for 2013. All upgrades to Clinical/Critical applications/services are filtered through mandatory redundancy requirements for D1/D2 DataCentre configuration.
Nov-12	Chapter 3(5)	Work in Progress	Meetings have been held with IWK IT management and IWK Emergency Planning. Review of existing DR plan underway ensuring alignment with All Hazards Approach. This includes revision, testing and structured walk through. DRP updated for review and currently updating Appendices.
Nov-12	Chapter 3(6)	Work in Progress	IWK is reviewing existing DR Plan ensuring alignment with All Hazards Approach. This includes revision, testing and structured walk through.
Nov-12	Chapter 3(7)	Work in Progress	Necessary hardware has been purchased for the secondary site and the main IWK hospital information system. Meditech will be moving to the provincial data centre within three to four months once the technical work has been completed to prepare for this move.
Nov-12	Chapter 3(8)	Work in Progress	Capital Health has identified risks for evaluation. Work is underway to define a risk assessment matrix to quantify risk weight and strategies. The risk matrix will be defined for changing protection levels of Capital Health and Nova Scotia health threats.

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Nov-12	Chapter 3(9)	Work in Progress	IWK software Implementation planning underway to implement necessary technical software solution by March 31, 2014; resources permitting.
Nov-12	Chapter 3(10)	Work in Progress	Capital Health RISK matrix for threat/impact will be defined for UNIX & Windows security models with various account types (user, service, system, and administration). With the introduction of Single Sign on, there will be enhanced security for the Emergency Department. Information System.
Nov-12	Chapter 3(11)	Work in Progress	Databases are updated as releases become available from the vendor in combination with resource availability. The IWK is developing a list of secondary databases that require migration to SQL with implementation of security controls. The Provincial Personal Health Information Audit Policy is currently in draft and will be applied to these databases in order to prioritize the list for migration.
Nov-12	Chapter 3(12)	Work in Progress	Single Sign-On continues to be implemented throughout the IWK as resources are available. IWK is undertaking a review of all clinical systems where there is functionality to better control usage of passwords and locking accounts is enforced.
Nov-12	Chapter 3(13)	Work in Progress	Related work at IWK is currently underway reviewing accounts, permissions and developing appropriate policies. However IWK is discovering how complex and labor intensive this work is. This is a health centre wide initiative that requires input from all service areas.
Nov-12	Chapter 3(14)	Work in Progress	At Capital Health various solutions (patches) have been identified and mitigation options are under consideration. Related policy development and implementation planned for completion December 2013.
Nov-12	Chapter 3(15)	Work in Progress	Capital Health's updated Application Services Matrix will include elements required to determine end-of-life status for applications. Implementation of enterprise wide clinical documentation will replace many smaller departmental clinical documentation systems. Other potentially more cost effective partnerships to enable health information solutions are being evaluated. Outcomes from this exercise may change the approach and response to addressing this AG recommendation.
Nov-12	Chapter 3(16)	Complete	Relating to IWK, vendor recommended security patches have been installed during regular monthly down times.
Nov-12	Chapter 3(17)	Work in Progress	All Capital Health applications have been surveyed to determine auditing capabilities. 203 existing systems were surveyed of which slightly over 50% contain patient information and 35% have audit capabilities. Next steps will be to determine to what extent the audit capabilities are being leveraged.

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Nov-12	Chapter 3(18)	Work in Progress	Capital Health's plan is to define a minimum standard set of requirements for applications that will protect patient information. As new patient applications are being explored efforts are made to align functions with PHIA requirements which includes the auditing functionality. The risk is always assessed to balance specialized and unique patient care needs with potential risks of varying degrees of audit capability.
Nov-12	Chapter 3(19)	Work in Progress	Capital Health is planning the Implementation of periodic audit patient-related application logs in coordination with its Privacy Officer.
Nov-12	Chapter 3(20)	Work in Progress	IWK's technical issues have been resolved and Meditech is flowing into Fairwarning, an application which runs random checks on the system. Additional resources for auditing of IT systems is being assessed.
Nov-12	Chapter 3(21)	Complete	IWK now requires a Privacy Impact Assessment as part of the new RFP/Criteria selection process. Technical issues described in the Auditor General's November 2012 have been resolved. The FairWarning audit system is now considered functional for auditing the IWK patient information system (Meditech).
Nov-12	Chapter 3(22)	Work in Progress	Utilizing the Fairwarning application, IWK is producing audit logs for review on a regular basis. A provincial working group of PHIA custodians has developed a provincial auditing policy in compliance with PHIA. IWK will be developing an audit plan that includes a list of all electronic information systems, a risk matrix and a schedule for auditing each system (with auditing capacity analysis) based on risk.
Nov-12	Chapter 3(23)	Work in Progress	Capital Health's plan to coordinate with provincial practices for physical security management (Young St. Data Centre) is underway. Capital Health have engaged with Engineering/Security services (vendor) to implement changes for keys & access. Mechanical changes will be on-going as discoveries present.
Nov-12	Chapter 3(24)	Work in Progress	Capital Health's data centre will conduct a physical vulnerability assessment to update information.
Nov-12	Chapter 3(25)	Complete	IWK developed and implemented a new process regarding any users requesting access, security/ maintenance staff must request access which can only be approved by IT managers. Logging visitors to the data centre has been implemented. Ongoing monitoring of the swipe card access system ensures that only those who should have access to the IT department, have access and that departing staff access is removed on their last day of employment. This is being received and reviewed at least quarterly by the IT Manager.
Nov-12	Chapter 3(26)	Action No Longer Required	Given the planned move of the IWK Data Centre to HITS-NS the necessity for an IWK vulnerability assessment is no longer necessary (see 3.7). HITS-NS will be facilitating a vulnerability sssessment for the provincial data centre in the next fiscal year.

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Nov-12	Chapter 3(27)	Work in Progress	Currently Capital Health's terms and leaves reports are reviewed daily to ensure actions executed as requested. There is a plan to implement an audit trail with signed documents as evidence. The process will include thresholds for audit frequency based on outcomes of previous audits.
Nov-12	Chapter 3(28)	Work in Progress	Capital Health service desk process improvements are under development addressing resetting locked-out accounts or creatng new accounts.
Nov-12	Chapter 3(29)	Work in Progress	Capital Health's related process and forms are under review to ensure same standard.
Nov-12	Chapter 3(30)	Work in Progress	IWK is in the final stages of enhancing its process. Enhanced design of the on-line service solution to support this requirement is complete. IWK is developing a communication plan to ensure all IWK staff and managers are aware of the enhanced process with a launch targeted for June-July 2013.
Nov-12	Chapter 3(31)	Complete	IWK processes and practices have been implemented to ensure all users' access is removed once their employment has ended.
Nov-12	Chapter 3(32)	Work in Progress	Capital Health is investigating an "event log process" for all operating systems.
Nov-12	Chapter 3(33)	Work in Progress	Capital Health's process for investigation is underway, a report is being developed to define/identify dormant account criteria. Process for validation and action are being developed.
Nov-12	Chapter 3(34)	Work in Progress	IWK's dormant accounts have been reviewed and deactivated through the work of an adhoc process improvement working group. The Standard Operating Procedure is in effect.
Nov-12	Chapter 3(35)	Work in Progress	Capital Health is working with HITS-NS to implement a new provincial service desk application for prioritization of IT service requests. It is anticipated that this project will continue through the year. New standards for logging calls and helpdesk performance indicators will be established.
Nov-12	Chapter 3(36)	Work in Progress	Capital Health's IT incident management process documentation is being reviewed with IT helpdesk staff and sign off on a design package is planned for the first quarter of fiscal year 2013-14. The incident management process includes a new prioritization matrix.
Nov-12	Chapter 3(37)	Work in Progress	Meetings at Capital Health are being held with IT Helpdesk staff to review procedures and define activities.
Nov-12	Chapter 3(38)	Work in Progress	IWK has implemented a change in practice.The response to the incident is now included in the ticket.A procedure document is currently in development.

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Nov-12	Chapter 3(39)	Work in Progress	IWK's new provincial incident and problem management platform is scheduled for implementation in Fall 2013 through HITS-NS.
Nov-12	Chapter 3(40)	Work in Progress	Capital Health is reviewing mandatory fields and compliance options are under development.
Nov-12	Chapter 3(41)	Work in Progress	Capital Health's security levels are being reviewed with the implementation of service software. Standards of practices will be updated.
Nov-12	Chapter 3(42)	Work in Progress	Capital Health and HITS-NS is currently planning to implement a new system. No effort is planned to modify the system scheduled for sunsetting. The new system is being examined for required auditing capabilities and configuration options. Education or lunch and learn sessions will be scheduled, to refresh usage rules and guidelines.
Nov-12	Chapter 3(43)	Work in Progress	At IWK practice change has been implemented. Supporting documents are in development.
Nov-12	Chapter 3(44)	Work in Progress	Capital Health's IT organizational structure is under review to better support process adoption.
Nov-12	Chapter 3(45)	Complete	IWK's central list of on-going projects was developed in Microsoft project in November 2012.This project list has been populated for all IT services and each project's status is updated on a regular basis.
Nov-12	Chapter 3(46)	Work in Progress	The development of Capital Health's policy for data classification is underway for implementation before end of fiscal year 2013-14.
Nov-12	Chapter 3(47)	Work in Progress	Capital Health is currently doing a review and update of standard operating practices. With over 250 applications and a large data centre, this review will take time. Focus will be on the large and most critical systems that are at the enterprise wide level. The short term focus will be on the helpdesk and device deployment group. All procedures are being updated as new software is implemented in this area. The documentation for applications' upgrades and maintenance is also being updated. The set up of a new storage system will have supporting documentation. A plan will be incorporated that will survey level of compliance and document in our Application matrix.
Nov-12	Chapter 3(48)	Work in Progress	Capital Health is reviewing options within the server environment to project capacity needs. Thresholds for capacity limits have been set and work is underway with provincial colleagues to develop a capacity plan for future needs.
Nov-12	Chapter 3(49)	Complete	Based on expected attrition levels and project demands, Capital Health has a high level of confidence in its ability to support existing systems and future demands. New requirements will be evaluated in light of provincial initiatives.
Nov-12	Chapter 3(50)	Work in Progress	Using its online learning system (LMS), Capital Health is considering options for executing and tracking compliance.

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Nov-12	Chapter 3(51)	Work in Progress	Capital Health will review its policy exception policy documentation to ensure exception wording is clear.
Nov-12	Chapter 3(52)	Work in Progress	IWK's work is on-going with the provincial IT Leadership Consolidation. Under Merged Services Nova Scotia a provincial approach to policy development, including standardization and consistent controls will be a priority over the next year.
Nov-12	Chapter 3(53)	Work in Progress	As noted in 3.52 a provincial approach to policy development will be undertaken. This will include a process to ensure policies are up to date.Some of the IT policies have been reviewed and updated in April 2013, including Policy 303.1 Security of Electronic Information; Policy 315.1 Internet Access; Policy 320.1 Confidentiality; and Policy 319.1 Security of Secondary Linked Databases.
Nov-12	Chapter 3(54)	Work in Progress	IWK's Privacy Manager has developed a new confidentiality/privacy pledge for all new employees. Provincial Privacy leads have completed the E-Learning module. All IWK staff will be required to complete this training. Pledges are currently being signed by all IWK staff/volunteers with a target completion date of June 1, 2013. A privacy e-Learning module is complete and will be rolled-out to IWK staff to complete over the next year. PHIA training sessions were conducted in Jan/Feb 2013 and made available for all IWK staff/physicians/volunteers.
Nov-12	Chapter 3(55)	Work in Progress	Capital's IT control framework is being assessed in conjunction with work related to the other recommendations, such as the risk assessment and evaluation of hardware and software. Capital Health has targeted finalizing this in 2014-15 as resources will be focused on the other recommendations in the short term. As many of the recommendations are interconnected, many will have small segments completed as Capital Health works through the completion of all its recommendations.
Nov-12	Chapter 3(56)	Work in Progress	IWK's related work is on-going and with the provincial IT Leadership Consolidation under Merged Services Nova Scotia, a provincial approach to policy development, including standardization and consistent controls will be a priority over the next year.
Nov-12	Chapter 3(57)	Work in Progress	Capital Health's best practice is being reviewed against risk management and mitigation processes in order to develop improved tracking, reporting and mitigation strategies.
Nov-12	Chapter 3(58)	Complete	Related to IWK, the residual risk column has been added to IT Risk Register.

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Nov-12	Chapter4(1)	Work in Progress	DHW is moving towards implementation of multi-year capital planning. There is now an envelope of funding annually for capital medical equipment and repairs and renewals. Predictability of funding in these areas allows DHW to plan more appropriately and provides flexibility to approve items that may cross fiscal years. For larger construction projects the planning process has begun for 2014-15. Infrastructure has a robust system that provides a theoretical evaluation of the condition of every facility for the next twenty years. Components of multi-year planning are also underway for several provincial initiatives. The Lab/DI initiative in particular is examining the inventory of equipment throughout the province and working on a multii-year capital planning framework for replacement.
Nov-12	Chapter4(2)	Work in Progress	DHW currently collects baseline data regarding site visits to various locations through the Management Information System (MIS). The submission form for medical capital equipment requests used by DHAS/IWK has been revised to enhance the collection of utilization information.
Nov-12	Chapter4(3)	Complete	DHW has revised criteria and will be actively considering site utilization data in the prioritization matrix used for funding allocation decisions. The current information collected from DHAs/IWK on the submission form for medical capital equipment is being used in the scoring of submissions. Criteria used for the scoring process for medical capital equipment has been revised to clearly reflect the use of utilization information.
Nov-12	Chapter4(4)	Complete	Infrastructure Management has included representatives from the DHAs/IWK on the under $90,000 prioritization committee for two years. The over $90,000 prioritization committee has been expanded to include representation from DHAs/IWK. This committee has met four times. The Capital Spending Manual provides additional information and committee terms of reference.
Nov-12	Chapter4(5)	Work in Progress	DHW is considering a project to improve processes for planning. This project would consider the resources required for capital medical equipment and put plans in place to make changes to staffing in the context of the current fiscal situation.
Nov-12	Chapter4(6)	Complete	Capital Medical Equipment Submissions Committee now includes representatives from the DHAs/IWK Vice-President groupings for Medicine, Operations, Clinical and Patient Care. Its first meeting was held in January 2013 at which point the revised criteria and weights were accepted and the scoring and ranking process for fiscal year 2013-14 was completed by March 2013.
Nov-12	Chapter4(7)	Complete	Representatives of the DHW Equipment and Infrastructure groups met to review the pairwise scoring system to resolve identified issues in the November 2012 Auditor General's Report. The Infrastructure Management group and Medical Capital Equipment Submissions Committee implemented the modified Pairwise Scoring System for 2013-14.

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Nov-12	Chapter4(8)	Complete	Capital Medical Equipment Submissions Committee has reviewed and are using a revised scoring approach for 2013-14. Requests were scored by groupings of similar equipment (beds and lifts, pharmacy, monitors / ventilators / anesthesia, lab, diagnostic imaging, infection prevention and control, diagnostic and treatment, surgical) rather than by the order of submission from the DHAs/IWK. This has enabled better consistency in scoring within groupings of equipment.
Nov-12	Chapter4(9)	Complete	DHW strengthened its documentation of decisions and supporting rationale by January 1, 2013. Meeting minutes for the equipment group established for fiscal year 2012-13 now capture information to support equipment scores for emergency submissions. Capital Medical Equipment Submissions Committee scoring spreadsheet has also been modified for fiscal year 2013-14 and documents the rationale for assigned scores.
Nov-12	Chapter4(10)	Complete	The Capital Medical Equipment Request form was revised to capture more information regarding impact on access and utilization.The criteria used for the scoring process has been revised to clearly reflect the use of population, patient impact and use of equipment.The weights of each criterion reflect relative importance of patient impact, utilization and access.
Nov-12	Chapter4(11)	Complete	DHW continues to review and revise decision-making processes to incorporate consideration of future cost savings including considering future cost savings as part of the approval process for equipment and infrastructure projects. DHAs may provide all costs savings initiatives for approval through the annual business planning process. Access to an envelope of funding annually now supports ongoing opportunities to look for future cost savings. The submission form has been revised to capture more information regarding efficiencies such as cost avoidance/savings or capacity increases that may be anticipated as a result of capital medical equipment and the criteria and weight used for the scoring process were revised to clearly reflect the use of efficiencies for capital medical equipment.
Nov-12	Chapter4(12)	Work in Progress	DHW worked with the Department of Transportation Infrastructure and Renewal (TIR) to complete three significant energy saving projects. In 2012-13, the team was able to assist all DHAs with energy saving projects. Fifty-four projects were completed with a total value of $3.5 million.The risks and rewards of energy saving contracts are currently under consideration.
Nov-12	Chapter4(13)	Work in Progress	The Guysborough Antigonish Strait Health Authority (GASHA) has consolidated all facility and program capital equipment requests into one consolidated list for 2013-14. South Shore Health Authority (SSHA) will investigate processes currently used by other government agencies to see how this issue is addressed.

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Nov-12	Chapter4(14)	Work in Progress	Capital Health has streamlined the process and automated ranking/weighted criteria have been developed. Requests are ranked with all submitted requests and lists are refreshed. A revised policy and procedure is under development. DHW is presently re-evaluating their current criteria weights. GASHA plans to review this rating scale when it is complete and implement it or another DHA's model that provides a simplified objective ranking system.
Nov-12	Chapter4(15)	Complete	Capital repair renewal projects have been consolidated and submitted to DHW for review for 2013-14. Each project is ranked individually by district staff and then reviewed by the provincial Infrastructure Repair and Renewal Committee. GASHA’s ranking process is consistent with that of all other DHAS/IWK.
Nov-12	Chapter4(16)	Work in Progress	Capital Health has improved tracking for equipment maintained by Biomedical Engineering. This is being made a perpetual practice and the information will facilitate and support the equipment replacement analysis and justification. Maintenance and Diagnostic Imaging also maintain the Health Association of Nova Scotia (HANS) equipment listings. GASHA purchased a license for Megamation to assist with this engagement. HANS is working with the vendor to expand the database potential. Configuration discussions are ongoing. SSHA is discussing a provincial approach to addressing this recommendation through the Clinical Engineering Services Advisory Committee.
Nov-12	Chapter4(17)	Work in Progress	Capital Health is completing required preventative maintenance (PM) on equipment that supports hospital and patient care in accordance with manufacturer's specifications, accreditation standards, governing bodies, labour acts and codes. Its Biomedical Engineering continues to review and improve its PM program. Asset Inventory and Online Work Order System has been enhanced. GASHA has requested Biomedical Engineering Services at HANS to review the SAP Asset Management solution to determine what opportunities exist in light of the Provincial Shared Services Review in Building Infrastructure and Asset Management. This review is still in progress and further action on the recommendation has been deferred until this work is concluded. Until automated processes are in place, GASHA will continue to use a hybrid of automated and manual processes to ensure that PM activities occur on schedule. SSHA has performed a review and prioritization of all current PM activities. PM activities will be completed by priority.