Health Canada Santé Canada

Final Audit Report

Audit of Primary Care Nursing Services

October 2010

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Executive Summary

First Nations and Inuit peoples receive health services through a unique combination of federal, provincial, and First Nations-run programs and services. The audit focused on the primary care nursing services which are supported by the First Nations and Inuit Health Branch in Ottawa and delivered by the Regions and Programs Branch in the field. Program activities were examined in the two largest regions, Manitoba and Ontario, where the majority of the 57 nursing stations across Canada are under direct control of Health Canada.

The objective of the audit is to assess the management control framework in place for the delivery of Primary Care Nursing Services relating to governance, strategic planning, risk management, results and performance measurement. The audit was conducted in accordance with the Internal Auditing Standards for the Government of Canada, and has examined sufficient, relevant evidence and obtained sufficient information and explanations to provide a reasonable level of assurance in support of the audit conclusion.

An integrated service model, across both responsible Branches, needs to be developed to better meet the needs of First Nations communities. This would require integration of primary care assessment, diagnosis, treatment and rehabilitation with Public Health prevention, preparedness, protection and promotion.

Each year the regions report an operating deficit. Last year it was $13.6 million in Ontario and $13.7 million in Manitoba. The deficits are largely attributable to costs associated with overtime and the use of contract nurses from the private sector. Program sustainability would benefit from a funding formula based on the specific primary care needs of the populations being served and adequate to support the achievement of the objectives.

The Department has been able to effectively identify and assess the risks related to the primary care nursing program. However, there has been an ad hoc approach to addressing key risks especially in the areas of recruitment, retention, training, responding to incidents, and accreditation. Nurses and management were very positive about the actions taken with regard to critical incident stress management program.

To date, specific measureable criteria have not been established for the overall objective of Primary Care which is to provide *"First Nations and Inuit access to the same quality and availability of services as the rest of the population living in similar geographic areas"*. The established outputs for primary care nursing are not adequately measured and are not well linked to the objective. There are also deficiencies in the collection, analysis and reporting of performance information.

A 2009 study noted that First Nations, on-reserve residents, were critical of the overall quality of health care currently available in communities. However, a strong majority

were satisfied with the quality of health care services they have personally received. These accomplishments are attributable to dedicated nurses working under difficult working conditions in isolated locations.

Management has agreed, with an action plan, to the seven recommendations which will serve to strengthen the management control framework for the delivery of Primary Care Nursing Services.

Introduction

Background

First Nations and Inuit peoples receive health services through a unique combination of federal, provincial, and First Nations-run programs and services. Health Canada has been partners with First Nations and Inuit communities as well as provincial and territorial governments to support a long term vision based on improving access to health services through better integration and adaptation.

In almost three-quarters of the 680 First Nations and Inuit communities, where current policies permit some form of "health self-determination", the communities are now served by First Nations' organizations. For example, Health Canada has either transfer or integrated agreements in British Columbia, Alberta, Saskatchewan, Quebec, the Atlantic Provinces and the Territories. Typically agreements are found in regions where there tends to be more developed capacity and greater access to other sources of health care services.

Health Canada's delivery model for primary health care, which includes primary care and public health, continues to evolve. In addition to using transfer or integrated agreements the Department has been actively pursuing service delivery through Tripartite Agreements which will further provide First Nations communities with increased control over health care services. Although the Department is pursuing these agreements, there remains a commitment and requirement to deliver quality primary care in those nursing stations still under its control. In particular, Manitoba and Ontario remain reliant on Health Canada for delivery in remote and isolated areas as a result of capacity issues and geographical factors (i.e. no road access) requiring a Federal presence which is not nearly as pronounced in other provinces.

Primary care nursing services are the first point of contact in the health system. The nursing station model of service delivery is currently based on registered nurses (herein, referred to as nurses) offering an initial assessment or triage of clients' health needs, and in partnership with the client the nurse decides to initiate services independently, with another health care provider, or may refer to the provincial health system. Nurses assess the health situation and determine if the need for care is urgent or non-urgent and identify the necessary actions to take. Critical, emergent and urgent care involves the immediate treatment of the injured and/or ill client. This could include situations with an immediate threat to life or function, acute trauma or illness. This is done in consultation with a physician and is supported by the First Nations and Inuit Health clinical guidelines. It often includes cases which involves securing and coordinating medical transportation, if the care requires a more advanced treatment team. Non-urgent care services include: preventive health care; episodic health assessments; problem identification; selection of treatment options; coordinating family care and follow-up; and the provision of consultation and referral services with other health care providers and institutions.

Nursing stations, managed by Health Canada, provide access to primary care nursing services on a twenty-four hour basis over seven days a week and to a lesser extent in some communities on a twenty-four hours over five days a week basis. Over the past five years (2005-06 to 2009-10) the annual costs associated with primary care nursing have increased from $81.7 million to $102 million largely due to an increase in contract nursing expenses.

Objective

The objective of the audit was to assess the management control framework in place for the delivery of Primary Care Nursing Services relating to governance, strategic planning, risk management, results and performance measurement.

Scope and Approach

The audit was undertaken by the Audit and Accountability Bureau in accordance with the *Health Canada Risk-Based Audit Plan - 2008-2009.* The audit was conducted in accordance with the Internal Auditing Standards for the Government of Canada, and has examined sufficient, relevant evidence and obtained sufficient information and explanations to provide a reasonable level of assurance in support of the audit conclusion.

The audit focused on the primary care nursing services which are supported by the First Nations and Inuit Health Branch (Primary Health Care and Public Health Directorate and the Office of Nursing Services) in Ottawa and delivered in the field by the Regions and Programs Branch. Program activities were examined in the two largest regions, Manitoba and Ontario, where the majority of the 57 nursing stations across Canada are under direct control of the Department. This included Manitoba - 21 nursing stations - and Ontario Region, Sioux Lookout Zone (one of four zones in Ontario) - 19 nursing stations. Site visits were made to regional offices in Ontario and Manitoba and to the nursing stations in Pikangikum and Sachigo Lake in Ontario, and Cross Lake and Oxford House in Manitoba.

The audit did not examine the First Nations and Inuit Home and Community Care Program, which is part of an integrated response to healthcare, as it had been the subject of a three phase review between 2004 and 2009. The audit did not include the Territories, as in 1997 the Department completed a transfer of hospitals, facilities and universal health services to respective territories through transfer agreements. The audit also excluded third party nurses under transfer or contribution agreements with First Nations and excluded the two Health Canada hospitals that are funded separately.

Audit criteria were drawn from the Treasury Board of Canada Secretariats' *Core Management Controls: A Guide for Internal Auditors.* The audit criteria were discussed

and agreed upon by the First Nations and Inuit Health Branch and the Ontario and Manitoba Regions (see Appendix A).

Findings, Recommendations and Management Responses

Governance

Audit Criterion

Authority, responsibility and accountability are clear and communicated.

The delivery of primary care nursing services is a shared responsibility between the First Nations and Inuit Health Branch and the Regions and Programs Branch. The First Nations and Inuit Health Branch has national responsibilities for program frameworks, program funding and allocation, coordination, communication, monitoring, data analysis, reporting and evaluation. In addition, the Branch provides advice and guidance on program delivery. The Office of Nursing Services is a division within the First Nations and Inuit Health Branch. It provides a national nursing perspective by leading initiatives, developing standards, maintaining policies and guidelines, and monitoring progress against objectives.

In 2008 Health Canada went through a realignment process. As a part of that process the Regions and Programs Branch (RAPB) was created and became responsible for frontline delivery of primary care nursing services through nursing stations, zone level operations and/or regional level operations. The new reporting structure has been documented and RAPB has identified that strengthening strategic partnerships will be a key strategic area of focus for 2009-12. This includes establishing, defining and communicating roles and responsibilities of partners and clients. Moreover, in the operational plans prepared by the Branches both Regions and Programs Branch and First Nations and Inuit Health Branch identified risks associated with the ability to control delivery of programs and services in the current decentralized model. In order for accountability to be met, roles and responsibilities need to be clearly defined and linked to performance objectives.

The program activity architecture is an inventory of all the programs and activities undertaken by a department or agency. The architecture groups together programs and activities that are related and links them logically to the organization's strategic outcomes. A review of Health Canada’s program activity architecture notes several activities aimed at bettering health outcomes and reducing health inequalities between First Nations and Inuit and other Canadians. Primary Care Nursing is part of a larger service delivery model offering health programs and services to First Nations and Inuit communities. As such, there are many overlapping programs which need to be better clarified so that the program structure reflects the manner in which primary health care programs are actually delivered.

In the delivery of primary care programs, the Department is experimenting with different models of care. The *National Nursing Innovation Strategy (2008-2013)* provides investments over five years to Regions to investigate new models of care and to pilot

projects in remote and isolated First Nation communities. The Strategy consists of four project streams: introduction of collaborative teams; integration of nursing and technology; introduction of new hours of operation in target 24/7 nursing stations; and national education. The goal of the strategy is to improve access to and quality of primary care nursing services and involves Regions and Programs Branch, Regional Nursing Services, First Nations and Inuit Health Branch - Home and Community Care and the Office of Nursing Services.

Specifically, in Manitoba, investments target collaborative team pilots involving the introduction of Licensed Practical Nurses, Mental Health Nurses, Public Health Nurses, telehealth coordinators and nursing station administrators into three of the larger nursing stations while in Ontario pilots involve the introduction of Registered Practical Nurses, Nurse Practitioners and Laboratory/X-ray Technicians in four large communities. To date, the Strategy has supported thirty-eight pilot projects involving all Health Canada regions under the four project streams. The intent of these pilots are to examine the impact of utilizing different skill sets and competencies in delivering primary care.

While the pilot projects are a positive step, an integrated service model, across both Branches, should be developed to better meet the needs of First Nations communities. This requires an integration of Primary Care assessment, diagnosis, treatment and rehabilitation with Public Health prevention, preparedness, protection and promotion. Early preventative actions to deal with native health issues have been shown to offset both primary care requirements and long term health issues.

Roles and responsibilities between the two Branches must be more clearly defined. The First Nations and Inuit Health Branch is in the process of creating a new Primary Care Strategic Direction, however, the Branch has not yet completed the work and it is unclear how Regions and Programs Branch is involved in this initiative.

Recommendation 1

It is recommended that the Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch establish an integrated service model which would combine primary care services with public health services. The new model should establish clear accountabilities for delivery.

Management Response

The Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch agree that, in certain areas, further clarification of roles and responsibilities are required. In particular, roles and responsibilities for the recruitment and retention of primary care staff among First Nation's Inuit Health Branch, Regions and Programs Branch and Corporate Services Branch are not clearly delineated. Work will be undertaken to provide such clarity and to communicate that information to staff.

With respect to the integrated model of primary health care, the Assistant Deputy Minister of First Nations and Inuit Health Branch agrees that an integrated service model that incorporates the range of primary care and public health services is the ideal approach for providing First Nations on reserve the service necessary to maintain and improve their health. This approach will be better reflected in the revision of First Nations and Inuit Health Branch's Program Activity Architecture and Terms and Conditions currently underway.

As the audit report indicates, pilot work is underway through the National Nursing Innovation Strategy and other activities to explore new models of care and improve primary care services in communities. Within the context of resource constraints and a decentralized model in which elements of primary care services in many communities are delivered by First Nations, work will continue to develop and implement an integrated model of primary health care.

Strategic Planning

Audit Criteria

The Department has operational plans aimed at achieving primary care nursing services strategic objectives.

An operational plan describes short-term ways of achieving milestones and explains how or what portion of a strategic plan will be put into operation during a given fiscal year. An operational plan is the basis for, and justification of a fiscal year operating budget request. Each fiscal year the First Nations and Inuit Health Branch and Regions and Program Branch prepare operational plans which include activities related to the delivery of primary health care. Although the operational plans include the various activities for the delivery of primary care nursing services, there is a need for better integration of activities.

The current objective for Primary Care is to provide *"First Nations and Inuit access to the same quality and availability of services as the rest of the population living in similar geographic areas"*. However, there is no comparative information available on the quality and availability of services in similar geographic areas to provide a basis for the delivery of service. Therefore it is difficult to provide an accurate conclusion on the achievement of the objective. For example, the Branches could not provide a workload analysis to demonstrate the relationship between the number of nurses and other health providers at the nursing station and the historical changes in the health needs of the population served. In addition, there was no analysis undertaken to identify if there is the right balance of professional staff to meet the requirements of each of the communities served nor was there an analysis to justify the operational objectives of the program.

A second factor impacting the overall planning for primary care activities is funding. The audit specifically examined the planning and budgetary documents for the Ontario

and Manitoba regions as they represent the largest user and expenditure of primary care nursing services. Each year, the regions report a deficit, which was $13.6 million in Ontario and $13.7 million in Manitoba last year.

The major contributor to the deficit, as confirmed by management, is attributable to the difference between the "planned" operating hours of the nursing stations and the "actual" operating hours. Several departmental documents reflect services as being provided seven days a week over twenty-four hours; yet the regional budgets are based on a five day a week model with regular working hours. This results in overtime and additional contract expenses for agency nurses which are not appropriately reflected in the planning and budgetary documents. Annual overtime costs in Ontario and Manitoba have remained relatively high and consistent at approximately $9 million per year while the annual costs for contract nurses have more than doubled in the last three years moving from $10 million to almost $24 million.

Primary care nursing program sustainability would benefit from a budgeting process that would accurately reflect on the specific primary care nursing requirements of the populations being served. Funding should be adequate to support the achievement of the objectives.

Recommendation 2

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch and the Assistant Deputy Minister, Regions and Programs Branch develop an operational plan with measureable objectives which are aligned to a budget that better reflects the actual cost for the delivery of nursing services.

Management Response

The Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch agree that further work is required with respect to better defining the measurable objectives related to primary care nursing activities. Analysis will be undertaken to delineate appropriate service standards and resourcing levels taking into account what is provided to other Canadians and the unique circumstances of remote and isolated First Nation communities. This analysis will inform the development of a new Clinical and Client Care model, including articulation of measurable objectives and standards (this will be further addressed in the response to recommendation 7). This model will be used as the basis for identifying gaps between the delineated standards and what is actually being provided in remote and isolated communities.

The lessons learned from the Nursing Innovation pilots identified in the response to recommendation 1 as well as the analysis of service standards and operational gaps will be used to further elaborate the new Clinical and Client Care model. This in turn will

inform any business case presented in order to obtain permanent funding necessary to effectively implement the model.

As the report observes, annual A-base allotments do not match operational requirements. In response, the Department has tried, for a number of years, to address the issue by seeking a permanent increase to funding levels. Funding has been obtained in successive budgets on a time limited basis only, thus constraining the development of operational plans and funding allocations based on increasing service needs. Efforts to obtain permanent funding to address the primary care services deficit will continue.

Risk Management

Audit Criterion

Branches identify, assess and respond to the primary health care risks that may preclude the achievement of program objectives.

Risk management is a systematic process that includes the practices and procedures used to identify and manage the risks. The main risks related to the delivery of primary care nursing have been known to management for a long time.

One of the many enduring risks has been a national shortage of nurses. This is expected to continue to put significant pressure on the mandate to provide primary care nursing services to First Nations, particularly in remote and isolated northern locations. This risk was also noted in Branch and Regional planning documents. In 2009, the First Nations and Inuit Health Branch went before the *Senior Management Board* and presented on nursing challenges and risks. It was noted that the shortage of nurses is an overall risk which correlates directly with recruitment, retention, training and budgetary constraints.

As well, a joint presentation was made by Corporate Services Branch and the First Nations and Inuit Health Branch to the Human Resources Services Management Committee on the impact associated with nursing in remote and isolated locations such as the decreased quality and continuity of care as well as professional and legal risks as nurses in remote and isolated communities typically require a broader scope of practice. In addition, they reported on the negative impacts related to longer term health prevention and promotion efforts. Lastly, they noted the increased use of agency contract nurses who come with varying levels of capacity, are more costly and can negatively affect continuity of care.

Clearly, the Department and the relevant Branches have been able to identify and assess the risks related to the primary care - nursing program. While management, at all levels, have identified and assessed the risks facing the program, there has been an ad hoc approach to addressing key risks especially in the areas of recruitment, retention, training, responding to incidents, and accreditation. However, nurses and management were very

positive about the actions taken with regard to critical incident stress management program.

Recruitment and Retention

Recruitment and retention research indicates that individuals tend to accept employment and stay longer when they feel valued and experience personal and professional growth. A key risk that affects the primary care nursing services program delivery is the ability to attract and retain nurses. Retention is affected by issues such as overtime, stress, professional and geographical isolation, poor work environment, limited access to continuing education, and limited professional and managerial support. Nurses are also reliant on a variety of services provided by Band staff including: security; administration; property maintenance; cleaning and infection control; and provision of x-ray technicians. Problems with the provision of these services have a negative impact on retention.

The First Nations and Inuit Health Branch and Corporate Services Branch presentation on *Health Canada's Northern Nursing Community* (January 2010) reported that the three year departure rate for nurses working in remote and isolated First Nations communities is 55 percent. These losses are most significant with younger nurses where they have lost 83 percent of the nurses under 30 years old and 69 percent of those aged 30-40.

On the national front, the Office of Nursing Services has developed a nursing recruitment, retention and marketing strategy. For example, the Office accepts nursing applications and inputs them into the *Nurse Recruitment Inventory System*. The system maintains a list of prospective candidates for jobs. The regions are able to tap into the system to look for potential candidates. There is also an Aboriginal Health Human Resources Initiative which is designed to attract more First Nations, Inuit and Métis working in health care fields. The program currently supports over 60 students. At headquarters there have been job advertising initiatives in newspapers and headquarters has been attending career fairs. Details on careers in nursing are also posted on Health Canada's website. However, the internet presence and recruitment strategy could be improved to better attract the "new generation" of nurses who make more use of electronic social networking sites. While the strategy is quite comprehensive, there are no measurement criteria. Consequently, there is little evidence to demonstrate the results of activities undertaken. The strategy needs to be evaluated and updated to include measurement criteria and to reflect current conditions and initiatives taken at headquarters and in the field.

Manitoba has taken an aggressive marketing approach to meet its recruitment needs. The Region has developed its own detailed strategic plan with specific activities and timelines assigned to staff. The strategy focuses on such initiatives as efficient and effective hiring practices, improved information management, organized marketing program, and evaluation through the collection of data on recruitment strategies and feedback from hired nurses. Manitoba has also developed an information package for prospective nurses and routinely makes presentations across Canada. Furthermore, the Region has

also developed a recruitment strategy specific for job fairs and specific for advertising. Over the past two years, Manitoba has been successful in recruiting 50 nurses and has improved the retention rate from 40 percent to 69 percent. While Ontario has full time staff devoted to recruitment, the region has lower rates of retention. For example, over three years Sioux Lookout Zone hired 50 nurses but lost 45 for a retention rate of 10 percent.

Difficulties in recruitment and retention has led to a greater reliance on the use of contracted agency staff, who represented 46 percent of the nurses in Sioux Lookout Zone and 41 percent in Manitoba. As mentioned, the continued turnover of Agency nurses also has an impact on continuity of care for the First Nations clients. Regional and Branch staff did not have any analysis undertaken of the actual annual costs associated with the use of agency, full and part time nurses, including overtime. Having full compensation related data (salary, benefits, overtime, travel etc.) would assist in decision making and deficit control. Estimates provided by three regions noted that the additional salary costs associated with an agency nurse are approximately $106,000 annually.

Even with contract staff in place, Sioux Lookout still has a 13 percent vacancy rate. As well, 5 out of 19 nursing stations had annual vacancies in excess of 20 percent. While a nursing station would not likely close due to lack of staff they are often under staffed resulting in a heavy work burden for the remaining nurse. For example, Sachigo Lake has a staff complement of three nurses, yet this station often operates with only two nurses who provide services round-the-clock.

Human resources management literature clearly shows the importance of exit interviews as a part of a retention strategy. The Department needs to improve its exit interview strategy to better capture information for analysis purposes and for refining its recruitment and retention strategy. While the Department developed a web based questionnaire, the system is not operating as designed and there is no analysis of exit information for future recruitment and retention initiatives.

A Nursing Strategy Forum has recently been created, with senior management membership, to address issues on recruitment and retention of nurses for remote and isolated First Nations Communities. Supporting the Forum is a Task Group which meets on a weekly basis and is designing a more comprehensive strategy. There are also a variety of formal and informal interactions between recruiters at the various levels including a marketing committee and some joint venturing on career fairs. However, recruitment activities are highly dependant on the initiatives of individual staff at each level. There is a need for a more structured and coordinated approach between national and local recruitment and retention initiatives. Recent success in Manitoba has demonstrated the benefits of having dedicated personnel at the regional level who have combined human resources, marketing and nursing experience.

Recommendation 3

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch, the Assistant Deputy Minister, Regions and Programs Branch and the Assistant Deputy Minister Corporate Services Branch, continue efforts to develop and implement an integrated national/regional nursing recruitment and retention strategy.

Management Response

The Assistant Deputy Minister's of First Nations and Inuit Health Branch, Regions and Programs Branch and Corporate Services Branch agree on the importance of continuing to develop and implement an integrated national/regional nursing recruitment and retention strategy.

In 2009, a Northern Nursing Task Team was established to explore options to address recruitment and retention of nurses working in remote and isolated First Nations communities in a coordinated fashion over the long-term. The Task Team is expected to provide recommendations in the coming year, including a number of short term activities aimed at improving the working conditions and work environment.

Training

Until 1997, the Department had an extensive national training program for nurses working at nursing stations, taught at a variety of universities. These courses ranged from four to eighteen months depending on the initial qualifications of the nurse. They continued as regional initiatives until 2004 when this training was no longer offered. Since then, the regions audited have developed orientation programs for nurses on a smaller scale and include two weeks of in class orientation and two to three weeks of on-the-job coaching. However, nurses and management identified that there was a need for more extensive training to better prepare them for working in remote and isolated locations. In 2009, Manitoba Region brought in a four month *Northern Clinical Education Program.* However there are only eight seats offered twice a year. As a result, many nurses have not yet had the opportunity to attend the training.

Although nurses have access to ongoing training and certification in a wide variety of specific topic areas, there is inadequate assurance that nurses are receiving the training due to nursing shortages. As mentioned, management from the First Nations and Inuit Health Branch are aware that nurses in remote and isolated communities typically require a broader scope of practice to work than is authorized by provincial regulatory bodies and are aware of the risks of operating outside of the legislated scope of practice but within departmental *Clinical Practice Guidelines.*

The Branch is currently seeking support from a university to develop additional courses for nurses specific to the delivery of primary care health services. The plan is to have three intakes a year to train fifteen nurses per session for a total of forty five nurses

trained a year in a university willing to offer the training. Unfortunately, to date no university has responded to the "request for proposal".

Recommendation 4

It is recommended that the Assistant Deputy Minister, First Nations and Inuit Health Branch develop a training program for new nurses that adequately prepares them to work in remote and isolated locations with the support of the Assistant Deputy Minister, Regions and Programs Branch who will have to provide access/time for nurses to receive initial and ongoing training.

Management Response

The Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch agree that Health Canada nurses require a training program which adequately prepares them to work in remote and isolated locations. In 2008, as part of the Nursing Innovation Strategy, Health Canada obtained funding to develop a coordinated national approach to education and training for nurses. Over the course of the five year initiative, the Education Strategy will undertake a number of activities including:

- Developing a national education program in an education institution;
- Providing distance education opportunities for nurses in order to meet the primary care mandatory education and provincial regulatory requirements;
- Orientation toolkit to support regions;
- Online Nursing Leadership Education Program; and
- Providing funding to support replacement costs for nurses to Regions while on training.

These activities will complement a number of regionally-led activities underway which aim to improve training for new and existing staff. These regionally-led activities will be documented and assessed in order that best practices can be shared across regions.

The Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch agree on the importance of addressing questions related to scope of practice. In addition to the education activities and occurrence reporting activities (see recommendation 5) to address the scope of practice matter, the Branches are working to seek a Ministerial Exemption under Section 56 of the Controlled Drugs and Substances Act to provide nurses with authorization to possess and carry out activities with controlled substances at First Nations health facilities that are managed by Health Canada.

Responding to Incidents

Health Canada has developed a program to respond to the risks associated with nurses encountering traumatic events. The goals of the program are to reduce the number and impact of critical incidences against nurses and accelerate the recovery of those who have experienced such an event.

The *Critical Incident Stress Management* (CISM) Program, piloted in 1991, was made available to all regions in 1993 to assist nurses when they encounter a serious incident that could lead to "post traumatic stress disorder and/or departure from working in First Nations communities". The Program reports that this could include such actions as dealing with the death of a child, multiple casualties, prolonged resuscitation attempt, and verbal or physical abuse. The support from the Program includes pre-incident education, access to a 24 hour crisis and referral centre telephone support, individual critical incident stress counselling, group debriefings and referrals to other support. Last year Manitoba and Ontario reported 1,530 requests for services. Nurses were very positive about the services provided. However, there are some concerns that there may be under reporting by both nurses and managers. As a result, they may not be making full use of the services offered potentially leading to unnecessary turnover.

Program managers and nursing management can also become aware of issues through the Occurrence Reporting System, implemented in 2006. Occurrences may include: security violation; violence against a nurse; community suicides/self harm; death; vehicular accident; disease outbreak; environmental issues; medical evacuations and substance use related issues. When there is an "occurrence" it is reported by the nurse on a standard reporting form. The intent of the occurrence reporting system is to provide management with a timely flow of information so that they may take corrective action and also to identify trends which may impact health, safety and delivery of programs.

Last year, there were 1,259 occurrences reported in Manitoba and 905 in Sioux Lookout Zone (certain of these occurrences may have also been reported in CISM). There is general consensus from nurses, management and the CISM Program Coordinator that there is significant under reporting of occurrences. Under reporting has been attributed to a lack of time and inadequate response by management. Moreover, there is a general concern that nurses, over time, become desensitized to negative situations and therefore no longer report.

Completed occurrence reports pass from the nurse through the chain of command for appropriate action - to the Nurse in Charge, then to Zone/Regional Nursing Staff and finally to the Office of Nursing Services for their information and action if required. A copy of the report with the actions taken is to be provided back to the initiating nurse within 72 hours in order to provide timely and effective response. Based on interviews and a sampling of completed occurrence reports it was noted that there is no "return to

initiator" as required. As a result, it is not surprising that there are reduced rates of reporting and increased dissatisfaction with the system.

The 2007 *Public Service Employee Survey Action Plan,* approved by the Departmental Executive Committee, made a commitment that the Office of Nursing Services, in conjunction with the Regions, would monitor and analyze occurrence reports and take appropriate action. Despite this commitment, monitoring and analysis at both the national and regional level is not occurring. Part of this is attributed to problems associated with the automated reporting function of the system and the Office of Nursing Services is working to find a solution.

Occurrence reports are also to be used to identify "nursing practice" issues such as: deviation from policy and/or standards; practicing out of the legislated scope of practice; medication malpractice; and personal medication abuse. Even though the policy notes that occurrence reporting is intended to be a non-punitive system supporting quality nursing practices, there remains a fear of punishment. Like other health care professionals, nurses have a professional requirement to immediately report practice issues that jeopardize client safety to their respective Colleges of Nursing and if they do not report, nurses put their professional license at risk. However, nursing management has been recently informed by Health Canada Legal Services that reports can only be made after *Access to Information and Privacy* (ATIP) clearance, if they contain personal information. In some instances, this hinders the nurses "professional obligation to report immediately" and places them in an ethical dilemma between employment and professional licensing obligations. Moreover, if "nursing practice issues" are not raised and effectively mitigated by Health Canada, it puts the Department at legal risk. Corporate Services Branch reports that the ATIP unit is currently working on a protocol document to govern such disclosure.

Recommendation 5

It is recommended that the Assistant Deputy Minister, Regions and Programs Branch and the Assistant Deputy Minister, First Nations and Inuit Health Branch address the issues related to occurrence reporting and work quickly to resolve" nursing practice" issues.

Management Response

The Assistant Deputy Minister of Regions and Programs Branch and the Assistant Deputy Minister of First Nations and Inuit Health Branch agree about the importance of continuing to strengthen occurrence reporting, providing feedback and follow up and analysing results to address recurrence of issues. Efforts will continue to address automation of the occurrence reporting system and deal with issues underlying under reporting among nurses.

The Audit Report correctly observes that there may be situations where nurses' requirements to report personal information to a provincial regulatory body may be

difficult to reconcile with the obligations of employees under federal privacy legislation. Work will continue to develop the necessary guidance for health professionals working for Health Canada to enable them to deal with these situations.

Accreditation

In 2000, the Department began an initiative to develop and implement a voluntary *Health Services Accreditation Initiative* that would provide assistance for First Nations and Inuit Community Health Centres to meet Canadian standards. Accreditation is completed by a not-for-profit independent organization that provides national and international health care organizations with an external peer review process based on standards of excellence. The key areas examined during the accreditation process are the service delivery of client care, information management practices, human resource development/management, physical environment; and governance/management practices. Building on the success in First Nations and Inuit communities' health centres the process has been extended to develop relevant standards for remote and isolated nursing stations. The pilot locations are expected to begin testing the new standards in 2011.

Despite successes in the Community Health Centres, there are concerns raised by nurses and management that it may be difficult for the Department to receive accreditation for some nursing stations based on existing conditions. These include the Department's ability to provide: adequate numbers of qualified staff to provide continuity of care; a safe and healthy work environment; and the need for improvements in the reporting of occurrences and disclosure of nursing practice issues. As well, during audit field work, instances were noted where there was poor control over the security of client information. Nurses also identified numerous concerns relating to infection control and the capacity of staff to maintain cleanliness standards. Lastly, nurses and managers identified medical equipment which is currently unavailable in some nursing stations that may impact on accreditation.

It is important to note that at the beginning of the accreditation initiative, several of these issues were identified in the Community Health Centres; however there is recent evidence to show that progress is being made at these Centres. For example, the *2009 Accreditation in First Nations and Inuit Health Services* report by Accreditation Canada reveals that the security of client files has improved and now has a strong compliance rating, demonstrating the effectiveness of a standards-based approach to health services.

Recommendation 6

It is recommended that the Assistant Deputy Minister, Regions and Programs Branch and the Assistant Deputy Minister, First Nations and Inuit Health Branch identify facility and equipment needs, and conduct an assessment of nursing stations to identify and respond to areas in which improvements are necessary to support accreditation.

Management Response

The Assistant Deputy Minister of Regions and Programs Branch and the Assistant Deputy Minister of First Nations and Inuit Health Branch will work with the external accrediting body to establish accreditation standards for remote and isolated nursing stations. This year, a number of pilots will be undertaken to test standards and assess their applicability.

In that regard, a preliminary assessment has been conducted to identify facility equipment needs. This information will be used to develop and update the standardized medical equipment list. New facilities are being designed consistent with the standards necessary for accreditation and existing facilities upgraded based on priorities set under the Long Term Capital Plan. Activities taken through Canada's Economic Action Plan investments in construction and renovation of health facilities have accelerated this work.

Regarding security of client information, Health Canada employees routinely double-lock at night in health facilities. As well, all clerks are required to sign a confidentiality form prior to their employment with Health Canada facilities and are also provided with privacy and confidentiality training as part of their orientation. Management will continue to provide training and suggestions on managing information to Band employed clerks. As well, for nursing stations to receive accreditation each Health Canada facilities will have to demonstrate sound information management practices.

Issues identified in the audit with respect to specific nursing stations will be examined on a case-by-case basis and addressed through the established facility renovation and recapitalization process or through other means as appropriate.

Results and Performance Measurement

Audit Criteria

Management monitors actual performance against planned results and adjusts course as needed.

Management is expected, as they implement operational plans, to track activities, address variances and report against operational planned commitments. There is a mid-year opportunity to identify any new activities being undertaken since the beginning of the fiscal year, the expected results and performance targets. This information is used by senior management at the year-end review of the operational plan to evaluate how departmental goals are being met.

As previously noted, the overall objective for Primary Care is to provide *"First Nations and Inuit access to the same quality and availability of services as the rest of the population living in similar geographic areas"*. To date, specific measureable criteria

have not been established for this overall objective. As well, the established outputs for primary care nursing are not adequately measured and are not well linked to the objective.

There are also deficiencies in the collection, analysis and reporting of the information. The Branches have not yet developed a performance measurement system that would measure Primary Health Care Nursing achievements and the related cost. While data on primary care nursing costs are maintained at the zone and regional level, there was only limited performance information collected and analyzed at either the regional or national level. The absence of appropriate data collection and analysis limits decision making. At one point, there was a proposed national project for developing a nurse workload measurement system but it has yet to be developed.

Activity logs are maintained in each nursing station. These logs record summary information on which client was seen, the diagnosis and the nature of the treatment provided. However, there was only limited roll up and analysis of log book information. Nurses have been asked to spend time recording daily work activities, but it is not evident what is being done with the data they input. This can impact on the quantity and quality of data entered into the system. Sioux Lookout Zone has developed a paper and electronic system for rolling up log book information. However, insufficient numbers of computers at many of the nursing stations makes it difficult to submit electronically. While the log book data is being collected, there is no evidence of any analysis of the data or comparison of trends over time. The Zone has identified a number of reports that could be produced monthly by the Nurse in Charge to facilitate the delivery of primary care nursing services. Unfortunately, due to both time and system limitations these reports are not being generated or reviewed.

Manitoba Region notes that it does not have the resources to work with nurses to identify if they are reporting consistently and reliably, nor to analyze the data they have. The Region occasionally runs an ad hoc query, but acknowledges the limitations in these reports given the potential lack of completeness and/or accuracy of the data. The Region does not currently provide a roll-up of data to headquarters.

Manitoba Region has noted the need for a quality assurance program to facilitate effective evidence-based practices and decision making. A Quality Assurance unit could be the focal point for: risk management (assessing, monitoring and mitigating risks); occurrence management and critical incident review (analyzing occurrence reports for corrective actions); performance reporting; audits (practice audits, procedural audits, narcotic audits, pharmaceutical audits); and accreditation issues.

Despite the lack of Branch specific performance information, Health Canada has in the past commissioned studies to look at First Nations health to gain an appreciation of overall service delivery satisfaction. The 2009 *First Nations Syndicated Study*, produced for the Department by an external organization, noted that First Nations, on-reserve residents, were critical of the overall quality of health care currently available in

communities. However, a strong majority were satisfied with the quality of health care services they have personally received over the past year. As reported in the study, these figures have remained essentially unchanged since 2005.

Resources need to be focused towards identifying what information is required to monitor and report on primary care nursing. Data collection puts a significant time burden on nurses and nursing management at the zone and regional level. Therefore, it is important that when data is collected it is used. Health care information needs to be accurate, reliable, and accessible and, should contribute to measuring and closing gaps. There is clearly a need for a standardized approach across the country. National automation of data requirements, with more computers at the nursing stations, would facilitate data analysis and assist with determining benchmarks for quality improvement.

Recommendation 7

It is recommended that the Assistant Deputy Minister, Regions and Programs Branch and the Assistant Deputy Minister, First Nations and Inuit Health Branch develop and implement an integrated system for results and performance measurement.

Management Response

As set out in management responses to other recommendations, the Assistant Deputy Minister of First Nations and Inuit Health Branch and the Assistant Deputy Minister of Regions and Programs Branch agree there is a need to strengthen performance and results measurement as an essential component of implementing an integrated model of primary health care. As part of the Authorities Renewal process, management will develop a set of indicators in the new Performance Measurement Strategy. As the new system is implemented, new reporting standards will be introduced and communicated to all regions.

Conclusion

Delivery of quality health care services is highly dependent on the dedication of Health Canada nurses working within difficult conditions in isolated locations. A 2009 study noted that a strong majority of First Nations, on-reserve residents, were satisfied with the quality of health care services they have personally received despite being critical of the overall quality of health care currently available in community. Improvements in the areas of governance, strategic planning, risk management, results and performance measurement will serve to strengthen program delivery and further support the nurses.

An integrated service model, across both First Nations and Inuit Health Branch and the Regions and Programs Branch, needs to be developed to better meet the needs of First Nations communities. Each year, the Regions report a primary care deficit. Consequently there is a need for a funding formula based on the specific primary care needs of the populations being served and adequate to support the achievement of the objectives.

While the Department has been able to identify and assess the risks related to primary care nursing program delivery, there has been an ad hoc approach to addressing key risks especially in the areas of recruitment, retention, training, responding to incidents, and accreditation. However, nurses and management were very positive about the actions taken with regard to critical incident stress management program.

Specific measureable criteria have not been established for the overall objective for Primary Care and the established outputs for primary care nursing are not adequately measured or well linked to the objective. There are also deficiencies in the collection, analysis and reporting of performance information.

Appendix

Appendix A: Lines of Enquiry and Audit Criteria

Lines of Enquiry	Audit Criteria
1. Governance and Accountability	Authority, responsibility and accountability are clear and communicated.
2. Strategic Direction	The Department has operational plans aimed at achieving primary care nursing services strategic objectives.
3. Risk Management	Branches identify, assess and respond to the primary health care risks that may preclude the achievement of program objectives.
4. Results and Performance Management	Management monitors actual performance against planned results and adjusts course as needed.