

P3 REPORT

# Risky Business

The Royal Ottawa Mental Health Centre:  
Ontario's first P3 hospital

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June 22, 2007



## **P3 Report: Behind schedule and \$51 million over budget**

**OPSEU Local 479, Royal Ottawa Mental Health Centre  
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### **Executive Summary**

The Royal Ottawa Mental Health Centre opened October 27, 2006. It is the first hospital in Ontario to be designed, built, financed and maintained by the private sector.

The hospital was originally designed to hold 284 beds at a cost of \$95 million. It opened two years later as a 188 bed hospital costing \$146 million -- \$51 million over the original target budget and significantly smaller than planned.

The problems encountered in the new P3 exceed a tolerable level of errors and omissions, inconvenience and risk. Problems have had a serious impact on operating efficiency and a devastating impact on staff morale.

**While the hospital claims the new facilities to be “state-of-the-art,” staff and patients have encountered a high-risk workplace. Some the most serious problems stem from cost saving measures:**

- No staff training for fire/safety evacuation.
- Washrooms and work areas are not accessible to electric wheelchairs.
- Ergonomic redesigns had to be redone in high traffic areas.
- Doors to wards are difficult to open geriatric patients have been caught between the doors.
- Shower heads in the geriatric unit are fixed, reducing a patient's ability to shower independently.
- Insufficient housekeeping staff to keep the building clean or to cope with a greater number of washrooms.
- Housekeeping staff is forced to clean during daytime hours only, thereby limiting access to washrooms and contributing to increased noise during clinical intervention.
- Sound insulation between offices is insufficient, compromising clinical work.
- Telephones are cutting out and email communication halts for several hours, wireless phone and fax have failed to work.
- Patients are not permitted to take juice with foul tasting medication unless they have a physician's order.
- Film developing equipment leaked chemicals onto the floor resulting in Carillion staff removing equipment from the old building and installing it in place of the new, poorly functioning equipment.

**The operator, Carillion, is responsible for the financial cost of operations which have the potential to conflict with the employers' clinical operations and the public interest. Lines of accountability and authority have become blurred:**

- Managers are unable to explain new costs and how these will impact budgets
- Carillion has determined which categories of health care workers are permitted professional designations on office door.
- Following a demolition accident, the P3 project manager directed workers to return to work in the absence of the employers' assessment through the Joint Health and Safety Committee.
- Carillion-run food services denied nursing a key to locked kitchens, preventing access to food for patients outside of meal times
- In order to cut costs, Carillion now runs the cafeteria using only disposable plates, cutlery and food containers, all going to landfills. Previously disposables were used for take-out only.
- Special diet orders for patients are not reliably provided due to new paperwork requirements introduced by Carillion and staff reductions in order to save on labour costs.

**The downloading of maintenance costs to clinical program budgets, has forced managers to dip into clinical budgets at the expense of patient care:**

- Hospital program budgets are billed for damage/maintenance considered by Carillion not to be due to "normal use."
- Program managers were surprised that they were required to budget \$3000 per year to cover upkeep costs. New rules about who pays for what are not clear.
- Clinical programs discovered that photocopy machines are not owned but leased. These programs must cover the \$93 per month lease costs for each machine from their budgets and pay a three-cents-per-page fee for printing.
- Carillion charges \$15 per visit to hang anything on an office wall.
- Each jug of tap water ordered for a meeting costs \$5.
- Managers are not allowed to view any of the signed contracts and are simply expected to accept the word of Carillion managers with respect to entitlements.
- Air quality tests were performed and \$500 was billed to the employees' program after complaining about a ventilation problem

**The Royal Ottawa Health Care Group (ROHCG) reported a balanced budget for the year 2005-2006. The ROHCG is predicting a \$2.9 million deficit for the current fiscal year.**

**We are asking the government to:**

1. Place the public trust above profit-making ventures and disclose all transactions involving public funds.

2. Monitor and intervene when the quality of patient care is compromised by cost-cutting motives so that savings are not made on the backs of patients and health care workers.
3. Step up inspection to ensure the centre is safe and secure for patients and staff.
4. Place a moratorium on all future P3 contracts until a full public fiscal and operational review can be done of the Royal Ottawa and William Osler facilities.

### **Behind schedule and \$51 million over budget:**

The renamed Royal Ottawa Mental Health Centre (ROMHC) was officially opened by Premier Dalton McGuinty on October 27, 2006. It is the first hospital in Ontario to be designed, built, financed and maintained by the private sector.

The government claims, as the first P3 (Public-Private Partnership) hospital, the ROMHC opened ahead of schedule and under budget.

When announced in 2001, the ROMHC was to be a 284 bed hospital estimated to cost \$95 million (see press release, Dec. 7, 2001, Brand New Royal Ottawa Hospital Approved). It was originally scheduled to open in 2004. In 2006 it finally opened as a 188 bed hospital and at a cost of \$146 million -- \$51 million over the original target budget and significantly smaller than planned.

The rush to open the facility six weeks ahead of schedule has generated speculation about the reasons behind it. Was this a political maneuver gauged to impress the public with claims of efficiency as the first Ontario P3 hospital? Did bonuses accrue to some of the parties as a consequence of the early move?

In the public announcements about the project, it was revealed that payments would not begin to flow to the consortium -- The Healthcare Infrastructure Company of Canada (THICC) -- until the building was occupied. Regardless of the reasons, staff and patients were moved into a building that was neither complete nor fully tested and operational prior to occupancy.

As staff began the move into the building, they were surprised to find themselves working alongside hard hat construction crews, noticing piles of construction debris in the corridors.

At the time of the move construction of the final wing of the building had not yet begun. The expected occupancy date for this final stage of construction was given as July 1, 2007. Construction on the wing came to a halt without explanation for about two months. Construction workers indicated that they were awaiting "approvals" and rumours surfaced that negotiations between the parties had reached an impasse over new alterations to the project. When construction appeared to be resuming, staff were told the Ottawa Withdrawal Management Centre (commonly known as the Community Detox Centre), sponsored by the Hôpital Montfort would be a tenant of the new youth wing. A revised occupancy date was announced for the first quarter of 2008. No similar public announcement has been made. In fact shortly after the June announcement construction once again stopped. The announcement had sounded quite definitive but now the CEO, Bruce Swan simply referred to ongoing discussions.

## **Background: Privatization and the Royal Ottawa Hospital**

The former Royal Ottawa Hospital (ROH) led the way in privatization within the health care community in 1995 with the most extensive contracting out of support services to date. CEO George Langill and the Harris Conservative government adopted the term “hotel services” to describe the dietary, housekeeping and maintenance services, asserting that these services delivered in hospitals were no different from the same services delivered in hotels. They further asserted that the contracting out of these functions would permit the organization to concentrate on the delivery of its “core” services and result in significant cost savings. Many health care organizations would follow.

The failure to recognize the special skills required delivering these services in hospital settings was a slap in the face to workers who daily met varied patient needs and carefully maintained infection control practices. The policy turned a blind eye to the international experience, where contracting out of these services led to a causal increase in infections both in long term care facilities and hospitals. The human and financial costs directly related to these infections eclipse any possible savings derived from cutting staff and driving down wages.

The McGuinty government appears to be somewhat sensitive to these negative outcomes and has been narrowing the scope of P3 projects. Land privatization was the first to go. In January 2007 the province announced it was taking out ancillary services from all new P3 arrangements. In the case of the ROH, service privatization was extended with the contracting out of all Information Technology (IT) services in tandem with the P3. Many new P3 deals are being limited to short term financing, while a handful continue to use private borrowing on a long term basis. A leaked government document indicated private financing costs would push the price tag of the North Bay P3 above \$1 billion over the 30 year deal.

In 2001 the Royal Ottawa led the way with the announcement of a Public-Private Partnership deal to redevelop the hospital. Harris Cabinet Ministers Jim Flaherty, Tony Clement and John Baird were on hand to confirm the government’s commitment to the deal that would see the new Royal Ottawa Hospital privately built, operated and owned. The new 284 bed hospital was to be built at an estimated cost of \$95 million for occupancy in May 2004. All existing buildings were to be demolished, including a full service building, the Lady Grey, completed just 13 years earlier at a cost of just under \$13 million. In December 2002 the Ottawa Citizen reported the deal had been capped at \$100 million and project manager, Graham Bird, a former ROH Board member was quoted as saying that he hoped the consortia bids would come in below that estimate.

The ROH P3 became the subject of controversy during the October 2003 Ontario election. With McGuinty pledging to bring the deal back into the public sphere, the hospital made every effort to push the deal through, especially with polls showing Tory victory unlikely. The hospital insisted that cancellation of the deal would result in

\$10 million in penalties payable to the consortium. The figure was later revealed to be \$2 million.

Following the election, Premier McGuinty made a few cosmetic changes to the deal and in July 2004 gave the final approval for the deal between the Royal Ottawa Health Care Group (ROHCG) and The Healthcare Infrastructure Company of Canada (THICC). The consortium consisted of the financier, Borealis; the builder, Ellis-Don; and the operator, Carillion. After McGuinty signed a similar deal he opposed during the election, former Harris Cabinet Minister and Tory MPP John Baird said of the Premier: "his tie may be red but his suit is blue".

While the project had been reduced in size and now promised only 188 beds rather than the originally planned 284 beds, it would be designed and built at an inflated cost of \$126.8 million according to figures released by the hospital and would not be ready for occupancy until late 2006. The total cost of the financing and operation of the building over the 20 year 8 month term was estimated by the hospital to be \$256 million. Payment would begin once the building was occupied and was to cover the mortgage for the facilities; all utilities, including heating, air conditioning, and lighting; food and linen services; security, housekeeping, ground maintenance, and ongoing maintenance. A 'life cycle' program was to be built into the deal which would ensure that the facilities would be kept in a 'like-new' condition for the duration of the agreement and continuously maintained. In September 2005 the hospital announced that the construction on the new building would be complete on December 17, 2006.

Critics of such deals rarely have the opportunity to review the figures relied upon by hospitals and P3 consortia in making such claims as the parties cite commercial secrecy in refusing to release the figures and analyses to public scrutiny. However, after nearly four years of fighting the government and the same P3 consortium (THICC), a group of unions including OPSEU and the Ontario Health Coalition won a court order for the release of documents pertaining to the Brampton P3 deal.

An analysis of the newly released documents from the Brampton P3 by economist Lewis Auerbach, a former Director with the Office of the Auditor General of Canada, suggests that the Brampton P3 deal may be costing taxpayers an additional \$130 million dollars over a traditionally built and operated hospital. In his review of the Deloitte and Touche report commissioned by the government at the time the deal was approved, Auerbach concludes that the cost of the public sector comparator may have been over estimated by \$300 to \$400 million. One of the selling points for the deal was that a public sector project would not generate tax revenue whereas it was estimated that THICC would pay \$187 million in taxes. However, by the time the contract was signed that figure had shrunk to just \$7 million. Steven Shrybman, the lawyer who led the charge for the release of the documents concluded that the approval of the P3 project amounted to a betrayal of the government's obligation to manage the public purse. For full details visit the Ontario health coalition web site at <http://www.web.net/ohc/>.

Similar documents pertaining to the Royal Ottawa P3 deal pursued through the same legal action are expected to be released at any time.

### **Eight-month Review of the P3 Experience:**

A degree of fine tuning is to be expected in any new facility. However, the problems encountered in the P3 exceed a tolerable level of errors and omissions, inconvenience and risk. Problems have had a serious impact on operating efficiency and a devastating impact on staff morale. Many of the serious problems could have been entirely avoided by involving end users in the design phase of the project in more than a superficial manner.

The judgment of those leading the project has also come into question -- particularly with respect to the wireless environment. To put it simply: is a hospital an appropriate testing ground for an unproven wireless technology?

In the eight months that have elapsed since the opening, some problems have been corrected, some have been improved upon while others have remained persistent and some simply too expensive to remedy since the costs would be charged to the hospital budget and not that of the P3 consortium.

Ongoing problems cluster around three main themes:

- 1. State of the art facility vs. high risk workplace**
- 2. Who is in charge of what? Blurred lines of accountability and authority**
- 3. Downloading maintenance costs to clinical program budgets**

#### **1. State of the Art Facility**

The ROMHC describes this new facility as “state of the art.” The Ministry of Labour (MOL) has made several visits to the new facility as part of its high risk initiative. Violations to the Health and Safety Act have been cited by the Ministry.

#### **Security:**

- Areas of hospital open to public at night, staff working alone without an emergency system in place, skeleton security staff at night.
- Recently a partially glassed in reception area designed without a video camera in the work area was broken into two consecutive nights in a row. A computer and phone system were stolen. Prior to this incident Carillion had been alerted to the gap between the glass and ceiling. Security guards or cameras did not capture the thieves.
- Since opening as a P3 the security system failed on two occasions when patients eloped (unauthorized leave).

### **Emergency response preparation:**

- No training for staff on fire/safety evacuation.
- Not enough keys for all areas, for emergency access.
- Inpatient units evacuate to a courtyard. Staff complained that the exit gate was padlocked from the outside, making it difficult to unlock. Staff expressed concern that under stressful circumstances it would be difficult to unlock the gate. Further, once outside, one cannot get back into the building. Staff have been propping the courtyard door open, circumventing fire regulations, because of a lack of access to keys. (Padlocks are being moved to the inside of the gate and additional keys are being issued.)
- No flag system in place to indicate a room has been cleared during an emergency evacuation.

### **Health and safety:**

- Staff requests to have their office furniture rearranged into safer configurations were treated as “low priority” by facility services (Carillion) despite a commitment by the hospital prior to the move that office set up would be in accordance with best practices regarding staff safety. Staff that moved their own furniture were told they had voided the warranty on the furniture - only Carillion and/or Ottawa Business Interiors (OBI) staff can move the furniture.
- Debris from the demolition of an adjacent building fell against the new building, damaging the roof and windows. It also placed staff and patients at risk. Promised safety shielding had not been put in place prior to the demolition. This situation posed an ongoing hazard to staff occupying offices impacted by the debris. One member was unable to return to work for several weeks after the incident. OPSEU intervened immediately and the area was cordoned off until the remaining demolition was completed and the Occupational Health and Safety Committee (OHSC) deemed the area safe.
- A sliding glass door in a reception area shattered after being closed. The glass was supposed to be engineered to shatter into small blunt pieces to reduce possibility of injury. Instead, small sharp pieces of glass flew across the room. Fortunately no injuries resulted.
- Patio doors in the geriatrics unit lock on own – staff/patients have to bang on a window to get someone to let them back in.
- Geriatric inpatient units have long corridors; many patients wander or are at risk of elopement (unauthorized leave). This poses a serious risk for patients who suffer from dementia and may be unable to assure their own safety. If someone rings to be let in, there is no way to see who that person is, or monitor comings and goings.
- Ergonomic redesign of the pharmacy area and switchboard/reception areas are underway due to serious deficiencies in this regard.
- In April, a fire alarm was sounded. Employees responding to it could not find the room the alarm was activated from. It was necessary to retrieve a map in order to continue the search for the room, significantly delaying the emergency response.

- In May, when a fire alarm sounded, no announcement was made as to the location. Staff was confronted with closed metal gates at the top of the central stairwell and along a gangway crossing the central atrium. Apparently these are safety features. Staff still have not been advised that they should avoid these areas when attempting to evacuate the building.
- Promised parabolic mirrors to eliminate blind spots were installed seven months post-move.
- Eye wash stations are not accessible to people who work with chemicals and prepare medications and need to be able to rinse their eyes immediately if exposed.

### **Communication systems:**

- Bell landlines were installed four months after the move to enable “red” emergency phones to be accessible to staff and visitors as a result of the persistence instability/unreliability of the wireless system.
- Cafeteria emergency phone was installed at a considerable distance from staff work station.
- Forensic nursing station is so soundproof staff are unable to hear altercations between patients.
- Phone problems continue eight months later. Dropped calls, inability to hear or be heard continue. Many equipment upgrades required.

### **Accessibility:**

The design team failed to consult with staff in order to match workplace design to the work performed and to adhere to universal design standards. Instead the minimum standards of the building code were adopted which, unlike universal design standards, do not assure accessibility. Staff requests to make design changes were rejected.

- Washrooms not accessible to electric wheelchairs, entrances difficult to navigate.
- Doors cannot be opened by persons with certain physical disabilities.
- High counters in many reception areas are difficult for persons in wheelchairs to engage with staff.
- The doors to clinical/ward areas are difficult to open – door closers provide considerable resistance. A staff member cannot simultaneously swipe a security access card, hold the door open, and guide a person with a mobility device without risk of injury. This is an event that is repeated a multitude of times in a day on the geriatrics unit.
- Geriatric patients have been caught between the two sets of heavy doors leading in and out of the unit.
- A staff member who temporarily required the use of a wheelchair was unable to come to work, because her area -- like most -- is not accessible.
- Insufficient clearance in several washrooms for people who use electric wheelchairs.

- High counters in many reception areas inappropriate for persons using wheelchairs.
- Washroom grab bars are designed in such a way that patients cannot have a safe, secure hold. Patients have difficulty raising themselves off a toilet as a result nursing staff must assist them by squeezing into the tight washroom space and lifting. Once standing, patients cannot hang onto the bar, because the bar does not allow for a full grip. In the Geriatrics unit, many patients are at risk of falls. Both they and the staff who assist them are at risk of injury.
- Shower heads in the Geriatric unit are fixed, instead of flexible hose heads. This reduces a person's ability to shower independently, and makes them dependent on attendant care. Attempts to change these by installing economical flex hose heads from Canadian Tire were not successful - they don't fit.
- Clear Plexiglas surrounding the Winter garden, on the second and third floors, does not have any markings/cues to enable a person with some visual impairment to avoid colliding into it.
- Occupational Therapy requires a universally accessible kitchen. Pre-construction consultations and agreements were not carried through. The kitchen stove and sink remain inaccessible for individuals who use wheelchairs.
- Closet rods were not installed until two months after the move.
- Despite moving into the new facility at the onset of winter, no coat hooks were placed in clinical and reception areas.

**Odors:**

- Diesel oil smells because of trucks operating near air intakes persist.
- Poor ventilation: Grease smells from cafeteria grill area waft through offices.
- Sewer odors were prominent in parts of the building in the first few months.

**Signage:**

- Signage is confusing and inadequate. Visitors complain of getting lost and turning in circles. Exit signs are few and far between.
- Floor maps continue to be unreadable.

**Housekeeping:**

- Insufficient housekeeping staff to keep the building clean – there are more washrooms to clean in the new facility, yet there is no increase in staff.
- Housekeeping staff must rely on clinicians to let them in to certain areas do their jobs. If the clinician is busy with clients or off the unit, the garbage is not picked up and the office is not cleaned for days. Staff has resorted to putting garbage in hallways, which creates obstructions.
- Housekeeping staff is forced to clean during daytime hours only, often limiting access to washrooms just before lunchtime when use is predictably increased. Increase in noise is a problem when clinicians are administering sensitive tests, conducting an interview, or involved in other interventions where it is important to have minimal noise.

### **Clinical Issues:**

- Confidentiality is extremely important in the area of mental health. When staff moved in, they discovered office and group room doors with an eleven inch wide window running three quarters the length of the door. Mylar film was installed after numerous complaints about lack of confidentiality for patients, but only over the mid section of the window.
- Staffs complain that sound insulation between offices is inadequate.
- Privacy is essential in patient care: There is no built-in mechanism to indicate if the room is occupied or that a session is in progress. Such mechanism would avoid interruption of clinical activities or people trying to peer over or under the Mylar film on the mid section of the window. This is quite disconcerting to patients. It is standard practice to protect privacy and avoid interruption through a sign on or beside the door which reads, "Interviewing" or "In Use." There is still no remedy.
- Lack of privacy is also evident in many treatment and activity rooms adjacent to the central atrium and main hallway. These areas are equipped with windows along their full breadth to let in light. These became the focus of staff and patient complaints related to issues of privacy and distraction due to passersby.
- Similar violations of patient privacy in clinician offices adjacent to atrium with floor to ceiling windows. Staff also complained of excessive heat in these offices. One staff had to wear a visor due to the intensity of the sunlight.
- Blinds in patient rooms turn transparent at night, become detached and fall to the floor. Sharp edges on blinds also present a hazard.
- A patient lounge located adjacent to the main elevators and with a window along its full length had a sign which read "Substance Abuse Lounge." The sign was finally removed in response to the objections of staff to disclosure of the problems of patients using the lounge.
- Accurate medication instructions are critical to patient care: Doctors are not able to give clear instructions to pharmacies because of the phones cutting out, or simply not being heard properly. Some phone messages and email communications are delayed several hours or dropped completely.
- Reporting lab results quickly and accurately is critical to patient care. An incident took place in December where the wireless phone and fax systems failed to work and a staff member was unable to give a paramedic critical documentation of a patient's blood results. The patient was transferred by ambulance to an acute care hospital without the benefit of lab results.
- The need for low noise levels in sensitive clinical areas: The fire and emergency/public announcement system are "integrated" to save money. As a result the public announcement function cannot be turned off in clinical areas without also turning off the ability to hear a fire alarm.
- Patients are not permitted juice to take with foul tasting medications unless they have a physician's order. Water is instead provided. This is a cost saving measure to Carillion, the operator.

- Diagnostic services darkroom was not provided with sufficient room-darkening capacity for reading scans. This meant repeating tests on patients, exposing them to further and unnecessary radiation. The problem was later corrected.
- Diagnostic services newly built architect-designed film developing equipment was poorly designed and leaked chemicals onto the floor. Carillion staff had to rip out the equipment in the old building and install it in place of the new, but poorly functioning, equipment.
- One-way mirrors in observation rooms placed above seating height - forcing staff to stand, or search for adjustable-height chairs. No audio systems were installed for these rooms. Audio systems from the old buildings were left behind and demolished.
- Kitchen sink taps in areas where clients are taught life skills do not allow enough clearance for washing of pots or dishes, resulting in water spills.

## **2. Who is in charge of what? Blurred lines of accountability and authority**

### **“New way of doing business”**

- The “new way of doing business” has not been clearly explained to managers or to front-line staff, despite repeated requests for clarity. Several months following the move, managers are unable to clearly explain to staff what the new costs are and how these costs will impact budgets.
- New rules about what can/cannot be moved into the new facility meant that staff watched the old buildings being demolished and sent to landfill complete with beds, desks, light fixtures, parabolic mirrors, phones, wastepaper and recycling bins, file cabinets and shelving units. Many of these items could have been used in the new facility or made available to social support agencies. Administration insisted that any old furniture (from the former buildings) coming in to the new facility had to be “approved” -- few were. This was described as an infection control measure. In other cases, denial of such approvals seemed to be based on a preoccupation with aesthetics.
- The Lady Grey, a 19 year old full service facility (built in 1987 for \$13 million) was demolished. This building was an asset to the Ottawa community that could have served a variety of community agencies -- including the Ottawa Withdrawal Management Centre (Community Detox. Centre). Situating the latter program in the Lady Grey building could have avoided concerns associated with locating it next to the youth program in the new wing under construction. While the program is to have a separate entrance, security concerns remain.
- Following the demolition accident, OPSEU members were instructed to return to work in the area of the accident by the manager of the P3 project who made his own determination that the area was safe. This is an example of the P3 consortium usurping the authority of the Employer and the JOHSC. At OPSEU’s insistence, all staff and patients were evacuated from the area until the JOHSC was satisfied that measures taken were sufficient for a safe return to the work area several weeks later.

- The only title allowed on office door signs is “Dr.” This is a directive from Carillion. OPSEU objected to this disrespectful treatment of clinical staff. The matter remains unresolved.
- To save on costs, the new cafeteria uses disposable plates, cutlery and food containers. All going to landfill. Prior to this, disposables were used for take-out only.

#### **Food Services:**

- Food services (Carillion) keeps ward kitchens locked. Nursing has been denied a key, preventing them from accessing food for patients during non-meal times.
- Food services delivers food, such as puddings to mix medications into, or juice to treat low blood sugar, to the nursing stations. Food service will not take responsibility for the storage of these foods. Nursing must store these perishables in various fridges in nursing stations. No one monitors these fridges. They are unsanitary, contain expired foods, and mould.
- Special diet orders for patients are not reliably provided due to new paperwork requirements introduced by Carillion and staff reductions in order to save on labour costs.

### **3. Downloading maintenance costs to clinical program budgets, forcing managers to dip into clinical budgets at the expense of patient care**

#### **Hidden costs:**

- Hospital program budgets are billed for damage/maintenance considered by Carillion not to be due to “normal use.”
- Program managers were surprised that they were required to budget \$3000 per year to cover upkeep costs. New rules about who pays for what are not clear.
- As part of the deal for the wireless network, clinical programs are required to purchase cell phones out of their own budgets from Telus, even if they are already fully equipped with functioning phones. Prior to this, phones were purchased on an as-needed basis.
- Clinical programs discovered that photocopy machines are not owned but leased and that they must cover the \$93 per month lease costs for each machine from their budgets and pay a three-cents-per-page fee for printing.
- Employee complained of ill effects from ventilation; tests were performed and \$500 fee for air quality testing was billed to the employee’s program.
- Managers informed that furnishings for any currently empty offices must be paid for through clinical program budgets. Some empty offices were designated for future growth to be furnished as needed by the programs relying on new funding. However, some additional staff members were hired fairly immediately and this became an unanticipated expense which the programs had not budgeted for created cost pressures for managers.

- “Everything is a fight” is how one union member has described the process of trying to get clarity on costs and accountability. These sentiments are echoed by managers who are not allowed to view any of the signed contracts and are simply expected to accept the word of Carillion managers with respect to entitlements. This kind of information is very difficult to obtain and requires great persistence.
- Carillion charges \$15 per visit to hang anything on an office wall.
- The cost of installing Mylar film for privacy was passed on to clinical programs.
- Each jug of tap water ordered for a meeting costs \$5.
- It is less expensive for satellite offices of the hospital to remain in the community rather than to be repatriated to the P3 building.
- Originally commercial tenants were only to occupy the research tower. It appears now that additional tenants will be moving into clinical program areas in the main building, taking up space designated as growth areas for the programs.

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### **Early move into building under construction posed Health and Safety risks:**

OPSEU both through direct communications with management and through the reporting of health and safety concerns to the OHSC identified a number of measures which were necessary to assure safety in the new work environment. It became evident through these discussions that insufficient planning had been devoted to health and safety in the P3. While the ROHCG and THICC had made much of the P3 being a state of the art facility many safety measures fell well short of state of the art and many fell short of what staff had come to expect in the old buildings!

### **Communication systems:**

- Danger posed by absolute failure of communication systems (no phones or computers for first several days). Staff resorted to using personal cell phones, with limited success since the building is shielded.
- Physicians unable to communicate with pharmacies to renew patient's prescriptions.
- Clinical staff unable to receive calls from patients, community agencies, etc., to retrieve messages from same or to return calls. Some messages were simply lost and there was no way to alert others that their messages were not being received. The inability to communicate seriously compromised patient care. After a few days communications systems were functional for some of the time but notoriously unpredictable and unreliable.
- FAX machines normally relied upon to send and receive lab results and other reports for patients could only be used by designated secretaries, creating bottle necks. The fax machines often did not work at all.

- In the research tower and in other areas of the main building, the public announcement/fire alarm systems were non-functioning or not within hearing range due to sparsely located speakers.
- A staff member had to run to the switchboard operator on the first floor to report a medical code on the second floor in order for it to be announced and an ambulance called.

### **Emergency response preparation:**

- Inadequate preparation of emergency response personnel in advance of move with respect to the physical layout of the new building: some first responders received no orientation at all to the new site prior to the move. Familiarity with the new building was essential in order to assure a rapid response to emergency codes. Access to the new site pre-move was very limited and it was unclear whether this was due to it being an active construction site, the tenancy agreement, liability issues, etc. As a result there were delays in emergency personnel arriving at the site of codes to provide the needed assistance.
- Staff were not informed of available safety measures. Training still has not taken place.
- Promised emergency response measures (Ekahau personal safety alarms) are not in place. These were to have been available in advance of the move.
- Promised training for fire/safety evacuation failed to take place.
- Stairwell signs indicating safe exits were requested by OPSEU after discovering some exits led into fenced off areas, potentially trapping evacuees. Management indicated that evacuees could re-enter the building to access other exits. Letter-size paper signs were posted above the large red emergency exits signs which read: "Fenced area of refuge. Construction site beyond." OPSEU complained that these signs were too small to be noticed in an emergency. The wording also did not convey the danger of evacuating from an exit that might trap the person to within six feet of the building.
- Forensic medium security unit: doors not functioning properly and surveillance cameras not working. This is a unit where reliable security measures are essential.
- As a result of the security problems on the Forensic unit, patients were denied family visits for several weeks.

### **Odours:**

- Sewage smells.
- Diesel oil smells because of trucks operating near air intakes.

### **Signage:**

- Signs were inaccurate – naming offices and services that did not exist e.g., 'endoscopy', 'rehabilitation services', arrows on signs pointing the wrong way, high incidence of spelling errors. Off the main corridors, no names are provided - only room numbers.

- Insufficient signage to help orient staff, visitors and patients.
- Exits (or pathway to exits) unmarked. This is extremely frustrating for staff, patients and visitors.
- Floor plans provided to staff were produced in very small print and were unreadable.

**Office equipment, safety, access and ergonomics:**

- Safe office setup (to avoid staff being trapped in offices in dangerous situations) not in place as had been promised.
- Secretarial staff placed into cramped quarters with high noise levels and poor ergonomics while other offices remained empty.
- Many offices equipped with unusable storage units forced staff to improvise and stack patient charts, etc., on floors and desks. Many office areas are not equipped with mail slots and other standard operating equipment. Office staff has complained of a loss of efficiency and are pressured to work unpaid overtime to keep up.
- Staff placed in offices with no natural light while offices with windows remained vacant.
- Originally all clinical patient services were to be housed in the main hospital building. Only support services, research and commercial tenants were to be housed in the research tower. Safety concerns were raised about the location of clinical patient services in areas of the tower remote from other clinical staff.
- Lack of available keys to staff for their own offices. Staff had to rely on security personnel in order to access their offices for weeks.
- Active construction ongoing during move and beyond – workers adjusting ventilation, entering offices to check wiring, etc.

**Washroom facilities and drinking fountains:**

- No supplies in washrooms in the first few days. Locks on washroom doors not functioning.
- Some washroom taps were not functioning – an unacceptable risk in a hospital environment where infection-control is a priority.
- Limited access to drinking water - there are only two water fountains in the entire building. They are located on the third floor, outside the gym. The rationale given for this was that water fountains are not hygienic. However, this is a facility where patients frequently experience dry mouth or extreme constipation as a side effect of medications, and outpatients also need access to water for taking medications. Ministry of Labour later cited this as a violation of the Health and Safety Act.
- Water and ice dispensing machines located in locked areas. The cost of moving these machines was quoted as \$10,000 each and the hospital concluded that it could not afford the cost of moving the machines.
- No initial hand wash stations (installed later).

**Temperature regulation:**

- The temperature in the pharmacy narcotic vault was over 23 Celsius during the first month due to a closed vent. Staff attempts to use fans was greeted with the threat of confiscation.
- A number of offices were cold enough to require space heaters on an ongoing basis.

**A Cautionary Tale**

This report highlights the impact of placing cost-cutting measures above patient care when a third party builder is given control of operational decisions in a P3 project.

The McGuinty government has announced an additional 33 P3 projects in Ontario. In the interest of public accountability and quality health care, the government cannot continue to push forward with projects that undermine the delivery of services at the expense of the public purse.

**We are asking the McGuinty government to:**

1. Place the public trust above profit-making ventures and disclose all transactions involving public funds.
2. Monitor and intervene when the quality of patient care is compromised by cost-cutting motives so that savings are not made on the backs of patients and health care workers.
3. Step up inspection to ensure the centre is safe and secure for patients and staff.
4. Place a moratorium on all future P3 contracts until a full public fiscal and operational review can be done of the Royal Ottawa and William Osler facilities.