OPSEU LOCAL 479

Risky Business II

Hidden costs, security breaches, poor design, two-tier health delivery and very expensive water: one year later at the secretive Royal Ottawa Mental Health Centre, Ontario's first P3 Hospital

November, 2007

Executive Summary

The Royal Ottawa Mental Health Centre (ROMHC) opened October 27, 2006. It is the first public 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 as a 188 bed hospital costing $146 million -- $51 million over the original target budget and significantly smaller than originally 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. After one year of operation, many of these problems remain and others have come to light.

While the hospital claims the new facilities to be "state-of-the-art," staff and patients have encountered a high-risk workplace and the Ministry of Labour continues to monitor the implementation of issued orders. Hidden costs have strained clinical budgets impacting patient care and the public interest. Lines of authority have become blurred between hospital and P3 management as well as, more broadly, between the public and private sectors. Two-tier health services are being offered within the halls of the hospital, with a commercial fee-based clinical service operating alongside public services. Some of the most serious problems stem from ongoing cost saving measures:

- For-profit treatment offered alongside public services.
- The Ekahau personal alarm system promised to be in place in time for the move -- it still has not arrived.
- Inadequate security in temporary exercise yard resulted in escape from medium secure unit.
- Managers are unable to obtain contractual information with the P3 in order to manage and plan budgets.
- 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.
- Magnetic door locks have failed, preventing emergency response teams from entering/ exiting units.
- 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.
- Washrooms and work areas are not accessible to electric wheelchairs.
- Doors to wards are difficult to open and geriatric patients have been caught between the doors.
- Doors to patient rooms swing only one way, allowing patients to barricade themselves in.
- Shower heads in the geriatric unit are fixed, reducing a patient's ability to shower independently.
- Baffles behind grab bars prevent the user from securely grasping them.

- 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.
- The "wireless environment" remains problematic with persistent phone, fax and computer problems. Work is underway to hardwire high risk areas.
- Patients are not permitted to take juice with foul tasting medication unless they have a physician's order.
- Security design problems identified prior to the move are only now being corrected.
- In order to cut costs, Carillion now runs the cafeteria using only disposable plates, cutlery and food containers -- all going to landfills after use. Previously disposables were used for take-out only.
- 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.
- Air quality tests were performed and $500 was billed to the employees' program after complaining about a ventilation problem.
- Carillion refuses to mount display cases for patient art transferred from the old buildings because it does not match the décor. Carillion has not agreed to supply new ones.
- The hospital is restricted from using any contractor other than EllisDon for renovations, however small in scale.
- A dispute between the hospital and Carillion over payment for improvements resulted in a delay in action costing clinical budget staff overtime costs.

The Royal Ottawa Health Care Group (ROHCG) reported a balanced budget for the year 2005-2006 prior to the move into the P3. The ROHCG is now running a deficit resulting in layoff of clinical staff as well as senior managers. We continue to ask 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 on the Royal Ottawa and William Osler facilities.

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Hidden costs, security breaches, poor design, two-tier health delivery and very expensive water: one year later at the secretive Royal Ottawa Mental Health Centre, Ontario's first P3 Hospital

Privatization at the former Royal Ottawa Hospital (ROH) began in 1995 with extensive contracting out of support services (see OPSEU 479 report "Risky Business", June 22, 2007 available at http://www.opseu.org/bps/health/mental/P3RoyalOttawaReport.pdf for detailed history).

In 2001 the Harris government announced that the ROH would be redeveloped as a Public-Private Partnership (P3). The new Royal Ottawa would be privately financed, built, operated and owned. In 2002 the Ottawa Citizen newspaper reported that the deal had been capped at $100 million.

In October 2003 the Royal Ottawa became an election issue. On the eve of the vote Liberal leader Dalton McGuinty pledged to bring the project back into the public sphere. However, once elected, Premier McGuinty made some cosmetic changes to the deal and gave final approval for the deal between the Royal Ottawa health Care Group (ROHCG) and The Health Infrastructure Company of Canada (THICC) -- a consortium consisting of financier Borealis; builder EllisDon; and operator Carillion.

Critics of P3 deals contend that their secrecy prevents the kind of public scrutiny that is necessary to properly evaluate the value of such deals. Critical analyses on the information available conclude that they often lead to reductions in beds, staff and, ultimately, losses of service to the public. Hospital P3's lend themselves to a blurring of the lines between the public and private sector and may create opportunities for the poaching of patients from the public system by private for-profit interests. In the Royal Ottawa, a private for-profit fee-based clinic has opened alongside public services, opening the facility to delivery of two-tier health care.

The kind of problems encountered at the Royal Ottawa are likely to be repeated in some form at the recently opened William Osler Hospital in Brampton. Originally planned to have 608 beds at an estimated cost of $350 million, the cost escalated to $550 million by the time the contract was signed with the private for-profit consortium. In an October 26, 2007 press release, the Osler revealed the total cost is now $790 million. While the Osler public communications continues to claim they have approximately 600 beds, the hospital only opened with 479 beds. The 608 planned beds will not come into service until 2011/12, leaving the Osler with only 100 more beds than the Peel Memorial Hospital, which closed to make room for the new Brampton hospital.

Since the opening day, the hospital has been plagued with wait times issues, as the facility has been unable to keep up with demand.

Given the government's commitment to evidence-based decision-making, it is our opinion that there is significant and growing evidence to suggest it is time to take another look at this

method of financing and operating public infrastructure. Every Ontarian knows there is no such thing as free money - the hidden costs and serious quality concerns should be thoroughly reviewed before more such projects are undertaken.

One year anniversary marred by staff layoffs

The newly renamed Royal Ottawa Mental Health Centre marked its first anniversary in the P3 amidst staff layoffs attributed to financial shortfalls by hospital management. As the hospital conducts a recovery planning exercise in response to a growing deficit, staff are bracing for further layoffs. Entire programs may be on the chopping block.

Despite assurances from the McGuinty government to the contrary, the Royal Ottawa P3 has followed the pattern predicted by P3 critics: bed reductions and staff layoffs are taking place at the Royal, as they have in other jurisdictions at home and abroad.

Originally announced as a 284 bed hospital at a cost of $95 million it was officially opened by Premier Dalton McGuinty on October 27, 2006 with only 188 beds at a cost of $146 million (http://www.web.net/~ohc/P3s/ROHEconomistAnalysisNov2.pdf). No final cost has been released, with work behind schedule on a significant wing of the hospital.

Secret deals "poor value for money"

The Royal Ottawa P3 remains shrouded in secrecy. The exemption of hospitals from Freedom of Information (FOI) requests means the only recourse open to those defending the public interest is costly legal actions.

Four years after the Ontario Health Coalition, OPSEU, CUPE and SEIU took THICC (the private sector consortium) and the government to court seeking disclosure of documents related to the Brampton P3 deal, not all of the documents have been made available.

Of the William Osler P3 documents that have finally been released through the courts, the Ontario Health Coalition in May of 2007 asked for an analysis by economist Lewis Auerbach, a former Director of Audit Operations with the Office of the Auditor General of Canada. Auerbach concluded that the extraordinary costs of the project represented poor value for money and that the cost of the project, rather than being less than the public sector comparator, was significantly more. (See www.web.net/ohc/P3s/LAwohcMemoMay9Final.pdf)

Steven Shrybman, representing the unions/health coalition in court, characterized the approval of the P3 project as a betrayal of the government's obligation to manage the public purse. More recently economist Hugh Mackenzie has asserted that P3 projects cost approximately 1.5 times projects carried out in the traditional public sector manner.

Ahead of schedule and on budget?

The government's claim that the first P3 (Public-Private Partnership) hospital, the ROMHC, opened ahead of schedule and on budget is either a matter of very liberal interpretation or is quite simply at odds with the facts. The final product, as is typically the case with P3's, has grown in cost from the originally announced $95 million to $146 million (an additional $51 million) upon the awarding of the contract, while the bed count has shrunk from 284 to a mere 188 (see press release, Dec. 7, 2001, Brand New Royal Ottawa Hospital Approved).

As clinical programs began their move into the new building on November 1, 2006, it became clear that the facility was anything but "ahead of schedule". Amidst construction activity and debris, security and safety concerns identified prior to the move were proven justified. OPSEU lodged a formal complaint to the Ministry of Labour on November 3. After three days in the new building with no functioning phones or computers, staff harboured grave doubts concerning the advisability of transferring patients into the building the following Monday.

In the public announcements regarding the Royal Ottawa P3, it was revealed that payments would not begin to flow to the consortium, 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.

Phase One construction still incomplete at one year

Announcements at the time of the opening failed to mention that some areas fundamental to the functioning of the facility had yet to be completed. These included the loading docks, a secure exercise yard for residents of the medium secure unit and the sallyport, a self-contained secure area for prisoner/patient transfers.

After one year the temporary exercise yard remains in use. The temporary yard, along with a number of other security concerns, raised serious doubts about the advisability of making the move to the new facility, prompting last minutes contingencies.

An escape from the exercise yard led to a dispute as to whether the hospital or Carillion, the operator, would cover the cost of razor wire to replace barbed wire to thwart further escapes. Potential breaches in security place both staff and patients at risk. Hospital staff do not have the training of correctional officers to deal with such incidents. During this period, access to the yard was disallowed, leading both to formal complaints and a significant increase in tensions on the unit. This necessitated bringing in extra staff at a cost in the tens of thousands of dollars; a cost due to construction delays which is being absorbed by the clinical hospital budget.

Loading docks only came into use several weeks before the first anniversary. The sallyport came into use more recently, but was found to have been built too short.

The sallyport is designed to be closed off both to the exterior and interior of the hospital to permit secure and private transfer of patients/prisoners directly to the medium secure unit.

Prior to coming into use, orange jumpsuited and shackled patients/prisoners had to enter/exit the building from the main entrance in full public view. The security of the sallyport was also intended to provide an efficiency whereby the ROMHC would be added to the daily route of the Ottawa-Carleton Regional Detention Centre for drop off and pick up of prisoners. Since the \sallyport was built too short to accommodate this vehicle, additional travel arrangements have had to be made for transfer of patients/prisoner to and from the ROMHC.

Secret negotiations delay work on phase two

The expected July 1, 2007 occupancy date for the second stage of construction came and went. In fact, no activity was taking place on this final stage of construction.

With the exception of landscaping, the site remained deserted without explanation for about two months. When construction appeared to be resuming in June, staff were told that 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.

Shortly after construction slowed again. CEO Bruce Swan simply explained the delay as connected to ongoing discussions -- bringing the future of the expanded project into question. When a public acknowledgement was finally made in response to the probing of CBC video journalist Simon Gardner, no details were provided. To date, no information has been released concerning any changes to the P3 contract in order to cover the additional costs associated with the modification of construction plans to accommodate the new tenant. With change orders leaving the public at the mercy of the contractor, the secrecy of these deals stands in the way of public accountability.

Now well behind schedule and in a race to close in the new wing before the snow flies, construction workers are under pressure to move the work along quickly. Recently, when a worker suffered a broken collar bone as a result of a fall, at least one worker attributed this to the fast pace of construction.

Turmoil at the top

At the one year mark the ROMHC is headed up by an acting CEO and acting CFO. In a hastily called staff forum in October, the Chair of the Royal Ottawa Health Care Group board of directors announced that CEO Bruce Swan would be leaving the organization by mutual agreement at year's end. A few weeks earlier the CFO had left with no public farewell, and in the preceding months it was announced that the positions of VP of Integration and VP of Communications had been eliminated as a cost saving measure. Shortly after the departure of the VP of Communications, the manager of the Communications department also left without announcement.

Public-private: Blurring the lines

No commercial tenants are listed in the Directory for the Research Tower where such tenants were planned to reside. Private sector enterprises were to be housed separately to maintain the distinction between private-for profit enterprises and the public-clinical services of the hospital. However, a major commercial tenant, MindCare Centres, has set up shop in the hospital proper. One of the major concerns of P3 critics is the blurring of the lines between the public and private sectors that can occur in these projects and which can result in the poaching of patients by the private sector. With MincCare Centres operating within the walls of the hospital, it raises the spectre of two-tier healthcare directly within a public facility.

According to the November 15, 2007 edition of an Ottawa community newspaper, *The News EMC* (New mental health therapy at Royal Ottawa, page 22), "The Royal Ottawa Hospital is housing a clinic where mental health patients can access a new form of treatment using electricity. . ." The article further states "the government of Ontario has taken the position that there is not enough evidence of its efficacy to add it to the list of treatments covered by the provincial health plan." Does the delivery of such a service deeply embedded within a public hospital lend this commercial enterprise a level of legitimacy to which it may not be entitled? Might this also induce patients to invest in the $7000 cost of an initial treatment? What is the effect on less well-heeled patients who witness their peers entering into what is presented as a promising new treatment they cannot afford?

Entry into this treatment requires a physician's approval. At least one ROMHC psychiatrist is seeing patients in order to provide the necessary approvals. It is not known what financial arrangements govern these transactions which straddle the pubic and private systems.
Are public funds subsidizing this profit driven enterprise?

One year in the P3 - problems persist and new ones arise

A degree of fine tuning is to be expected in any new facility and some has been done. But other problems are fundamental to the design. Some have significant costs attached, and battles ensue over responsibility for such costs. Many staff have fallen victim to "reporting fatigue." Believing that problems will not be remedied, they often no longer report them. However, these problems continue to have a significant impact on operating efficiency and overall staff morale.

The judgment of those leading the project has also come into question -- particularly with respect to the wireless environment. When the acting CFO was asked who was responsible for the decision to embark on such a wireless environment, he responded that this was unknown and unimportant. Staff feels this response is a reflection of a broader lack of accountability. With other hospital projects coming on-line using similar wireless technology, such as Brampton's William Osler P3, evaluations must be undertaken to ensure patient safety, quality control and financial accountability. When asked who is footing the costs of hard wiring and other retrofits, the CFO acknowledged that the hospital is incurring these costs, which he said amounted to $100,000. However, sources claim that this figure reflected the amount the MOHLTC had agreed to reimburse the hospital. Total cost could be closer to as much as $1 million.

Security

- The Ekahau personal alarm system promised to be in place in time for the move -- it still has not arrived.
- Open reception areas identified prior to the move as vulnerable to violations of confidentiality, theft, and staff safety are finally being closed in.
- Over the past year security breaches resulted in three escapes from Forensic units. In one case, inadequate security in the temporary exercise yard resulted in an escape from the medium secure unit and a dispute between the hospital and Carillion over payment for improvements resulted in a delay in action costing the clinical budget for staff overtime.
- Only one security guard is available at night to accompany staff to the distant parking lot and to respond to emergency codes.

Wireless and other technology

- A process is finally underway to identify high risk areas and hard wire them -- beginning with nursing stations.
- The new IT manager announced at a staff forum that phones in high risk areas will be made independent of computers in order to mitigate risk. Stand alone wireless phones are not backed up, making them useless during a power failure.
- System does not have capacity for traffic, computer problems persist.
- Phone problems persist: Complaint calls are closed before being remedied or a complaint call is refused for lack of details, such as which number the complainant was calling when the problem occurred.
- Outsourcing of the help desk aggravates problems and causes unacceptable delays. Students on four month placements leave without every having been given an email account and new staff wait months for account assignment.
- Video monitors have not been working. These monitors are intended to allow staff to observe who is entering/exiting units in order to release door locks.
- Door lock problems on the medium secure unit permitted patients to lock staff out of the main ward area. Patients proceeded to try and kick out windows to an open area outside the building. Had staff been trapped with the patients, staff would have been at risk.

Health and safety

- A summary of the fire safety plan was finally released seven months after the opening. Confusion reigned during an earlier "Stage 2 Alarm".
- An Evacucheck flag system to indicate a room has been cleared during an emergency evacuation is just now being installed. There is not enough money to do office areas. Evac-u-sleds are available in the Geriatric unit but are not available for all disabled patients in other areas of the hospital. These allow for easy and safe evacuation of patients during an emergency.

- Response team members were unable to enter a unit during an emergency code when magnetic security doors would not unlock. Sealing in all inpatient units, the doors prevented staff from entering/exiting the unit or from providing assistance. Several previous incidents lasted from 30 minutes to two hours. It has been stressful for patients and staff prevented from entering/exiting the inpatient units. However, when an emergency code call was coincidental with one of these random lock downs, emergency responders were unable to access the unit calling the code to render assistance. News of this dangerous malfunction spread quickly throughout the hospital fostering a broader feeling of vulnerability. Staff has been authorized to pull fire alarms in such instances.
- 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 who 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. Several patients have been reported missing from the unit since the move. To date, they have been located within a relatively short time.
- Recommended ergonomic redesign of the switchboard/reception area due to serious deficiencies is not yet underway.
- Eye wash stations are not accessible to people who work with chemicals and prepare medications.
- During a summer storm skylights in the atrium area leaked, creating a slippery hazard (falls). Leaks were also reported in the Geriatric area.
- Limited access to drinking water: there are only two water fountains in the entire building. These fountains 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. Outpatients also need access to water for taking medications. The Ministry of Labour later cited this as a violation of the Health and Safety Act. Water dispensers have been installed on order of the Ministry of Labour, but are not equipped with disposable cups.
- Chairs with protruding screws in the seats -- identified at the time of the move -- were not repaired until 10 months later.
- Forensic nursing station is so soundproof staff are unable to hear altercations between patients or staff calls for help.

Food Safety

- Prior to the move into the P3, Food Service Supervisors made rounds of the various inpatient units throughout each mealtime. Since the move such monitoring and supervision is no longer routine. This has been attributed to understaffing of supervisors whose time is often tied up in administrative work.
- Dietary Aids who now must work without the supervision to which they were accustomed may not be equipped to maintain the same food safety standards with respect to proper food rotation and monitoring of out of date food.

Staff morale

After six months in the P3, the hospital repeated the employee satisfaction and empowerment survey conducted the previous year. Major findings included a decline in the satisfaction of employees with respect to management as well as a decline in satisfaction regarding physical safety. The top three suggestions cited by employees to improve physical safety included panic buttons, video cameras, and emergency procedures; improved layout for staff safety; and an improved landline phone system.

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.
- Baffles installed behind washroom grab bars prevent patients from securing safe and firm hold. Patients have difficulty raising themselves off a toilet. 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 improper kitchen stove, refrigerator and

sink remain inaccessible for individuals who use wheelchairs. Kitchen construction is still incomplete and in its current unfinished state presents a safety hazard.

Odors:

- Poor ventilation: Grease smells from cafeteria grill area waft through offices.
- Sewer and other odors remain problematic. Most recently a plumbing and mechanical contractor was called in to find the source of sewer odors occurring each morning in the front lobby and tower lobby.

Signage

- Signage and directionality remain a problem. Visitors and patients complain that the building is confusing and difficult to navigate
- Very few landmarks exist, many corridors looking exactly like others with no wall art or differing colour schemes to help patients and visitors find their way.
- The main entrance has been a source of confusion. A large single door opens to two smaller doors off to each side, only one of which may be operational at any given time.

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 11 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.
- Staff complains 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. All offices on the old site were so equipped.

- Blinds in patient rooms turn transparent at night, become detached and fall to the floor. Sharp edges on blinds also present a hazard.
- 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 by Carillion, the operator, which provides and controls all food services.
- 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.

"New way of doing business"

- To save on costs, the new cafeteria uses disposable plates, cutlery and food containers; all going to landfill after use. Prior to this, disposables were used for take-out only.
- Are financial pressures at the ROMHC behind the plan to move the Ottawa Withdrawal Management Centre (Community Detox Centre) from its current location in the downtown core to the P3? Staff has expressed concerns about its co-location with the Youth Program in the new wing now under construction. While the program is to have a separate entrance, security concerns remain.
- 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 hospital building, taking up space designated as growth areas for the programs.
- A recent commercial tenant is offering treatment services not covered by OHIP at a cost of $7,000 to patients - leading to questions about the blurring of lines between the public system and commercial interests. Is this the thin edge of the wedge with respect to the predicted poaching of patients from the public system predicted by P3 Opponents? A premium fee-based service raises the spectre of two-tiered health care delivery inside a public hospital.

Hidden costs

- Hospital program budgets are billed for damage/maintenance considered by Carillion not to be due to "normal use."
- Any renovations must be carried out by EllisDon. No outside tenders can be sought. Recently, the volunteer association was charged for construction expected to top $50,000 to partition their small space in order to accommodate vending machines. The

proceeds of these machines go to purchase patient comfort items. Other volunteer initiatives must now compete with commercial enterprises.

- 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 employees' program, not paid for by the P3.
- Managers informed that furnishings -- including computers and phones 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 immediately and this became an unanticipated expense, creating 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.
- When the P3 was requested to mount display cases brought over from the old buildings to display patient art work, staff was told several months later that they were not a priority. However, staff was informed the task could be moved up if they were willing to pay for the work. Eventually staff was told that the display cases could not be used because they did not match the décor. There is no word on who will pay for new ones.
- 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.
- 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.
- 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 resulting loss of efficiency and are pressured to work unpaid overtime to keep up.
- Staff is placed in offices with no natural light while offices with windows remain 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 remain about the location of clinical patient services in areas of the tower remote from other clinical staff.

Union friendly?

Eight months prior to the move it became clear that the smaller offices would not accommodate the storage of files related to union and pay equity matters. Consequently, space for storage in the new building was requested from the hospital. A year and four months later, the hospital indicated that it would arrange leased storage space from Carillion. The P3 quoted a cost to OPSEU of leased storage space to provide a single four-drawer filing cabinet was to be $2290 per year for each of three years. If OPSEU provided a filing cabinet the cost would drop to $1600 yearly; with the stipulation that rent was to be negotiated annually. At the time of the move into the new building, only 60 per cent of the space was occupied. Not only is the hospital paying out of its clinical budgets to add to the profits of the P3, but the union is being asked to chip in too.

In the old building union bulletin boards were located outside the cafeteria. In the new building Carillion insisted that they would be located in a service area well off the main corridor. When OPSEU protested, the hospital agreed to post a sign on the main corridor to direct staff to the location of the bulletin boards. Despite reminders from OPSEU, a year after the move this has not been done.

We are continuing to ask 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.