

Behind the Front Lines

A recap/critical look at health care news and the reality behind the reporting from the viewpoint of front-line Ontario registered nurses

Volume 3, No. 3
April 2011

Three Things You'll Learn in This Issue:

1. **Some hospitals pay two CEOs** ▶
2. **Link between RN staffing levels, patient risk** – [go](#)
3. **Communication breakdowns risky for patients** – [go](#)

New Report Shows RN Innovations Are Reducing Wait Times, Saving Money

A new Canadian Nurses Association (CNA) report says that registered nurses across Canada are shortening wait times in emergency rooms and other health care areas – and stepping forward with cost-effective and proactive solutions ([source](#)).

Entitled *Registered Nurses: On the Front Lines of Wait Times – Moving Forward*, the report highlights a number of successful nurse-driven solutions. They range from the use of mobile emergency nurses who are reducing ER wait times in Toronto by making house calls to long-term care residents – at a cost 21-per-cent lower than an assessment in an ER – to the use of nurse navigators to educate,

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Health Minister Deb Matthews, here speaking at an ONA event, has expressed “unhappiness and concern” with large payouts to former hospital CEOs revealed on the annual Sunshine List.

Release of the Sunshine List Exposes Some Surprises

The annual release of the provincial “Sunshine List” revealed a few surprises. Among them was the news that a former CEO from Ottawa is receiving a “golden handshake” worth at least \$1.15 million ([source](#)).

Montfort Hospital is paying former CEO Gerald Savoie \$557,622 in 2010; Savoie will receive another \$557,622 in 2011 – two full years after his departure.

The Sunshine List revealed Ottawa-area hospital CEO salaries that ranged from \$612,037 for the University of Ottawa Heart Institute’s Rob Roberts to \$642,037 for The Ottawa Hospital’s Jack Kitts.

Stories of high rates of hospital CEO salaries and large pay increases – despite the two-year public-sector employee wage freeze – popped up across the province, and SEIU President Sharleen Stewart’s opinion editorial was published on the subject ([source](#)).

In the Toronto area, Humber River Regional Hospital CEO Rueben Devlin saw a 10-per-cent salary increase, St. Michael’s Hospital CEO Robert Howard saw a 14-per-cent jump in compensation, and Sunnybrook’s CEO Robert Devlin saw his compensation package rise by 18 per cent over two years to \$693,000.

In Windsor, Hotel-Dieu Grace Hospital CEO Warren Chant received a 35-per-cent increase in salary shortly before he was fired.

Cliff Nordal, now retired from London Health Sciences Centre, received \$833,000, closely followed by Robert Bell, CEO of University Health Network with a salary of \$831,432.



What is ONA?

The Ontario Nurses' Association (ONA) is the union representing 57,000 front-line RNs and allied health professionals and more than 12,000 nursing student affiliates providing care in Ontario hospitals, long-term care facilities, public health, the community, industry and clinics.



Who is Linda Haslam-Stroud, RN?

ONA President Linda Haslam-Stroud, RN (pictured), is a veteran renal transplant nurse who is an expert spokesperson on a range of issues. Linda is available to comment on everything from workplace violence, patient care, health care policy in Ontario, the flu pandemic, nursing cuts, public health and much more. Simply contact ONA's media relations officer, Sheree Bond, at (416) 964-8833, ext. 2430 if you would like to interview Linda on a health-related issue.

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UNDER THE RADAR

News the Media is Missing

Another Research Study Shows a Link Between RN Staffing Levels, Patient Risk

Yet another in a series of studies has found that hospital units that don't have enough registered nurses on duty are hazardous to patients' health ([source](#)).

The latest research from the Mayo Clinic found a patient's risk of death increased by two per cent per hospital shift when units were understaffed by registered nurses.

Researchers looked at staffing at one hospital over four years and found that nursing levels met or were close to targets in about 85 per cent of all shifts. While the adequately staffed units had overall mortality rates lower than expected, patients in the units considered to be understaffed saw their risk of death increase by about 25 per cent when they experienced between 10 and 14 understaffed shifts during just five days in the hospital.

The study, published in the *New England Journal of Medicine*, clearly shows the importance of adequate RN staffing levels.

The researchers say that for hospitals that "generally succeed in maintaining RN staffing levels that are consistent with each patient's requirements for nursing care, this study underscores the importance of flexible staffing practices."

Lowering patient morbidity (complications) and mortality (death) rates through adequate RN staffing is something that ONA has been advocating for.

ONA's popular advocacy campaign urging Ontarians to recognize that dollar for dollar, RNs are the best value in health care, has continued with a new radio and transit shelter ad.

Preventing patient complications ultimately results in quicker discharge and lower hospital readmission rates, saving the health care system time and money.



ONA's advocacy campaign urges Ontarians to value registered nurses. The campaign's claims are backed up by yet another study showing that RNs reduce the number of patient deaths.

New Report, *cont'd from page 1*



RNs are reducing wait times and saving the health care system money with innovative ideas.

advocate, coordinate care and the system, which has resulted in better symptom management, patient follow-up, use of resources and fewer ER visits.

Canadian Nurses Association CEO Rachel Bard notes that RNs work in every sector of health care – public health, community health, family practice and primary care, etc. – and they understand that a multi-faceted approach is needed to lessen the impact of wait times.

The Association is calling for health care reform that puts patients at the centre of care, ensuring patients have access to the most appropriate providers, when and where needed. Bard says that RNs are skilled in promoting better health, providing more entry points to the system, collaborating as members of interprofessional teams, preventing and managing chronic disease, and providing quality care that improves health outcomes.

She also points out the evidence that when RNs provide care, patient complications are minimized, patients are discharged from care sooner and new patients thus have access to care more quickly.

What Nurses are Doing to Improve Wait Times

The CNA report details what RNs are doing to reduce wait times in Canada:

- 1) **Providing quality care and better health outcomes** – RN care reduces the average length of hospital stay and results in fewer patient complications, thus reducing readmissions and saving the system money. The skilled assessments they perform help patients achieve improved health. As researchers have discovered, increased RN staffing levels in acute-care hospitals result in better patient outcomes and significant hospital cost savings.
- 2) **Providing more entry points in the system and improving wait time patient experiences** – RNs are finding ways to care for more patients, implementing creative health-care delivery models, and enhancing nursing roles in varied settings. In a Toronto Western Hospital pilot project, Nurse Practitioners at the Surgical Spine Consultant Clinic significantly shortened wait times for patients awaiting an examination by a spine surgeon. The NP determined which patients were appropriate surgical candidates and referred them accordingly; of those examined by NPs, only 10 per cent were candidates for surgery – a diagnosis the surgeon agreed with in 100 per cent of the cases.
- 3) **Promoting better health** – RNs are taking the initiative to promote healthy living and better self-care. Public health nurses in Hamilton are involved in a pilot project of the Nurse-Family Partnership, a program that has been effective world-wide in improving pregnancy, health and social outcomes for low-income first-time mothers. Research has shown that these home visits are more effective when conducted by nurses and it's estimated that for every \$1 invested, the system saves more than \$5 through reduced health and social costs.
- 4) **Preventing and managing chronic disease** – Nurses are using their expertise in clinical management to develop prevention and management strategies to enable patients to reduce the risk factors stemming from their chronic diseases. In Calgary, RNs, physicians and pharmacists work together to address medical, social, lifestyle and other factors that affect health outcomes. At the end of its first year of operation, the total number of patient admissions for these patients had been reduced by 24 per cent and those who were admitted stayed an average of 51-per-cent less time.
- 5) **Collaborating as members of interprofessional teams** – RNs are working to provide comprehensive and holistic care with other health professionals. This has resulted in shorter wait times, increased access to and better coordination of care. In Ontario, when a Family Health Team integrates a nurse practitioner, 800 more patients per year can access care.
- 6) **Embracing technology** – Nurses are using telehealth, electronic health records and documentation, decision support systems and other technology to carry out clinical, educational, administrative, research and other health system initiatives. In Quebec, a group of home care nurses used laptops to complete patient documentation, enabling them to find 14 per cent more time to provide direct care. Improved efficiencies and time saved enable nurses to do 780 more home visits over one year.

Ontario Health Coalition Report Stirs Debate

A new report from the Ontario Health Coalition ([source](#)) called *Still Waiting: An Assessment of Ontario's Home Care System After Two Decades of Restructuring* has received widespread coverage in provincial media.

The report singles out funding and access to home care services as the two main problems in its assessment of the home care system after a full two decades of restructuring. There has been an extensive wait list for services in Ontario – persisting for more than a decade – that has totaled 10,000 people since 1999.

Other findings:

- Two policy shifts have strained the system – firstly, the movement of thousands of sicker and more complex patients out of hospitals to home care to save money; secondly, the dramatic reform of the governance and management of home care.
- For the better part of two decades, governments have cut hospitals but failed to create and enforce standards for accessing quality home care.
- The introduction of competitive bidding in home care has cut costs and facilitated privatization, leading to inadequate and rationed services, poor and inequitable access to care, ineffective or non-existent measurement of community need for service, high administrative costs, serious staffing shortages, privatization and ineffective measurement of quality and service delivery.

The OHC also notes that public input is virtually non-existent in home care now – noting that since the mid-1990s, there has been “no public consultation on the governance and provision of home care. Today, it is common practice for governments to consult almost exclusively with provider organizations and companies when forging public policy regarding home care. Unsurprisingly, policy has come to reflect private interests over the public interest.”

Privatization within the sector is in the form of for-profit ownership of provider companies and increased privatization of payment for services. The for-profit



delivery of home care services dramatically increased with the introduction of competitive bidding. Pre-1995, 82 per cent of providers were non-profit entities; now, 58 per cent are private, for-profit corporations.

As for funding, the report says that it has failed to keep pace with the downloading of patients from hospitals, with population growth and with aging Ontarians. Funding as a percentage of health care spending is declining for home care.

The bad news continues regarding oversight and quality of care. The report says that competitive bidding has resulted in the majority of the sector being privatized but failed to increase efficiency or improve quality.

Concerns continue regarding continuity of care, monitoring of providers and complaints.

Staffing shortages continue and are “a consistent and serious problem in home care,” and they are caused because the sector offers “significantly” poorer pay and working conditions, the province-wide shortages of RNs and other health care professionals and job insecurity due to competitive bidding.

For-profit corporations generally offer casual positions to their workers to reduce labour costs. As the sector becomes more and more privatized, work in it is temporary and precarious. The OHC concludes that “increased for-profit ownership has fed a lobby that works against an equitable single-tier home care program.”

In addition to coverage of the highlights of the OHC report ([source](#)), its release also inspired opinion editorials in several corners of the province ([source](#)).

The *Windsor Star* piece notes that more than 18,500 hospital beds have closed since 1990 and home care – which was to have taken up the slack – has been plagued by inadequate services, inequitable access and privatization. It calls for the reality of our home care inadequacies to be addressed and says it should become an election issue. Ignoring the problem for another decade will see the fix cost a lot more money, and possibly lives.

Communication Breakdowns Sometimes Difficult for OR, ICU Nurses

A comprehensive study by two nursing organizations has revealed that communication breakdowns can undermine the effectiveness of safety tools, leaving the potential for poor health outcomes for patients ([source](#)).

The findings of the study *The Silent Treatment: Why Safety Tools Don't Create Safety: People Do* are especially significant as health care providers and organizations depend more than ever on safety tools and checklists to prevent adverse patient events.

More hospitals in Ontario are introducing automated medication-dispensing systems and other tools.

The study showed that all the checklists, computerized order entry systems and automated medication-dispensing systems become ineffective if communications fail between health care professionals.

Of the 6,500 nurses and nurse managers surveyed last year for the study – conducted by the American Association of Critical-Care Nurses and the Association of periOperative Registered Nurses – 85 per cent said they have experienced the benefits of safety tools when they were warned of a problem. But 58 per cent also said they've experienced situations in which they felt unsafe about speaking up, or that others did not listen to them when they did so.

More than 80 per cent of the nurses also expressed concerns about dangerous shortcuts they see, such as professionals not washing their hands, as well as incompetence and disrespect demonstrated by their colleagues.

The lesson in these findings, says Linda Groah, RN, the Executive Director and CEO of the Association of periOperative Registered Nurses, is that much more work is needed in the operating room to support the surgical team's ability to establish a culture of safety, to encourage members to discuss errors openly and without fear of reprisals.

Federal Election:

National Nurses' Union Has Something to Say

In two public messages sponsored by the Canadian Federation of Nurses Unions (CFNU), the organization's President, Linda Silas, RN teamed up with Health Policy Professor Steven Lewis to talk about health care and the federal role and the effect of shrinking medicare on poverty rates.

The pieces appeared in *The Globe and Mail* in late April and gave voice to 176,000 registered nurses in Canada.

Lewis and Silas write that the federal role as steward of the *Canada Health Act* has atrophied, noting that it has been two decades since any government vigorously enforced it. The *Act* is violated daily by private health care clinics – a sign of “cynical resignation” by our governments.

The two suggest options to “learn from history and negotiate agreements that would serve Canadians better” than what is currently the case:

- 1) Convert the “tax point” system to have higher value in places with robust economies – an option should a decentralist government win a majority.
- 2) Simply extent the current health accord – like refueling the car rather than redesigning the vehicle.
- 3) Change the way services are delivered – spending used to compromise 60 per cent for hospitals and doctors, but today that figure is just 41 per cent.

The second piece sponsored by CFNU focuses on shrinking medicare and the effects on Canadians. They note that the biggest and fastest-growing gap in services impacts the care of seniors, prescription drugs, home care and long-term residential care.

Changes to the way long-term care is funded have resulted in a growing number of Canadian seniors becoming “functionally poor” as their discretionary income has disappeared to pay for care. Expanding home care would take the pressure off.

Silas and Lewis write that health care policy has resulted in financial poverty for many Canadians whose nominally adequate incomes are now spent on various forms of care. Principled and strategic federal leadership would right the ship, they say.

Salary Survey Shows Most American RNs Received a Raise Last Year

A new 2011 Salary Survey conducted by Advance for Nurses ([source](#)) is especially interesting in light of the number of Ontario-trained registered nurses who are continuing to cross the border to work in the U.S.

Survey results for American RNs working in the mid-Atlantic and lower Great Lakes states show that 60 per cent received a pay increase. Experienced nurses in the U.S. and those with advanced economic degrees and certification are also gaining ground.

Of the U.S. nurses who responded, those working in California earned the most, averaging \$90,815, up from \$86,786 in 2010.

In Ontario, registered nurses working in a hospital setting and who have 25 years' experience earn \$42.44 per hour; new graduates earn \$29.36 per hour in their first year on the job.

In some border cities such as Windsor, Ontario, hospitals have been running campaigns to try to convince Canadian nurses who travel to Detroit and area to work to return to work in our hospitals ([source](#)).

Nurses working in Detroit and other American cities cite better pay, better benefits, and better shifts as well as full-time – rather than part-time – employment for preferring to work in the U.S.

Looking for the real story?

Speak to front-line nurses!

The Ontario Nurses' Association has a whole host of experts in health care. ONA members work in hospitals, long-term care, public health, the community and industry and can answer your questions as health continues to evolve in this province.

Need a reliable and informed source? Contact ONA.



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Behind the Front Lines – an electronic newsletter that takes a look at the stories behind the stories. Great background info, insight and a resource for every journalist who writes about health care. E-mail shereeb@ona.org today to receive your copy.