

# ONTARIO NURSES' ASSOCIATION

## Submission on *Bill 46 – Excellent Care for All Act, 2010*

Standing Committee on Justice Policy

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## INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 55,000 front-line registered nurses 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 and industry.

Nurses strive to provide quality care for every patient on every shift. The provision of quality patient care is the central tenet of the nursing process. ONA has been advocating for appropriate resources and conditions of work to permit nurses to focus on the delivery of quality care in all sectors of our health care system. We welcome the opportunity to provide our frontline perspective to the Standing Committee on Bill 46 concerning the provision of quality care in our hospitals.

While ONA supports government action focused on quality patient care in Ontario hospitals, it is our view that Bill 46 falls short in a number of areas and we are concerned that it leaves much of the details to be developed in regulations. We agree with the overall direction in Bill 46 to create quality committees and publicly report on quality improvement in hospitals, but the processes for doing this require additional language in the Bill, not left to be developed in regulations.

In addition, a safety culture must be central to a quality practice setting, as we have learned from tragic experience during SARS what safety means in the health care sector.<sup>1</sup> Patient and worker safety must be considered together, not operating as "silos."<sup>2</sup> We think it is important that the notion of a safety culture – which embraces patient, worker and public safety – be explicitly embedded in legislation about quality in health care.

We also know that some existing hospital committees are not meeting their mandate as set out in regulation under the *Public Hospitals Act*. We are concerned about setting up an additional hospital committee when we know some existing hospital committees are not functioning as intended, especially without clear details in the Bill on the structure and operation of the quality committees. We also have reservations about the expanded mandate of the Ontario Health Quality Council without additional safeguards to protect the public interest.

Our submission begins by reviewing the problems with the functioning of some existing committees in hospitals as the context for our recommendations on amendments to Bill 46 to ensure quality committees achieve their intended outcomes – providing for the delivery of quality patient care in hospitals.

## **BACKGROUND AND CONTEXT**

Regulation 965 under the *Public Hospitals Act* currently sets out that every hospital board shall pass by-laws that provide for “the participation of the chief nursing executive, nurses who are managers and staff nurses in decision-making related to administrative, financial, operational and planning matters in the hospital.” Regulation 965 also provides for participation by the same group of nurses as above at the “committee level” as well.<sup>3</sup>

In addition, Regulation 965 provides that every hospital board “shall establish a fiscal advisory committee,” comprised of “one person representing staff nurses” in addition to other staff, and that “the fiscal advisory committee shall make recommendations to the board with respect to the operation, use and staffing of the hospital.”

Despite this clear language in regulation, the current practice is that many hospitals have not established a Fiscal Advisory Committee (FAC). In addition, some hospitals may have established a FAC but the FAC is not functioning as intended by the regulation: the FAC may not be meeting, it may be meeting infrequently or at times that do not coincide with the hospital budgetary cycle, the FAC members may not be receiving the information required to make meaningful recommendations to the hospital board, and the FAC is not making recommendations to the hospital board as specifically mandated under Regulation 965.

Fiscal Advisory Committees for hospitals were set up in regulation to ensure the involvement of staff nurses in a decision-making capacity on hospital committees. The former Minister of Health, Elinor Caplan, put it this way when she introduced FACs on February 15, 1989:

It is my pleasure to announce today amendments to the regulations governing the administration of Ontario's public hospitals which will give both nursing administrators and staff nurses a greater voice in decision-making in their institutions....Under the amendments, staff nurses and nurses who are managers will be represented on committees involved in the hospital's administration. These include, among others, the patient care committee, the utilization review committee, the occupational health and

safety program and the health surveillance program. In fact, nurses will have an active voice in administrative, financial, operational and planning decisions in their hospitals....I am also announcing today the establishment of a fiscal advisory committee on hospitals. This committee will be composed of representatives from the administration, the medical staff and the nursing staff. The fiscal advisory committee arose from the Conjoint Review Committee which looked into hospital operations last summer....It was the consensus of this committee that hospitals needed to develop strength in financial planning. The fiscal advisory committee will make that possible. Its mandate is to make recommendations to the hospital board on a wide range of subjects which will affect the operation of the hospital, how it is used and how it is staffed. I used the word "partnership" a moment ago. The Conjoint Review Committee also used this word. It felt that our hospitals need to foster a sense of partnership among their administrators and their staff who are involved in giving care to patients. The more co-operation there is among nurses, physicians, administrators and all of the people who perform their services in a hospital setting, the better the care their patients will receive and the more effective hospital administration will be. The membership on the fiscal advisory committee was designed to foster this partnership. However, we recognize that these initiatives are only part of the solution. They are but the first steps on the way to improving the quality of worklife for our nurses and involving them more fully in decision-making so that the entire hospital operation may benefit from their participation....

We agree that it is important to actively consult with nurses in hospitals, in a decision-making capacity, especially in the context of the impacts on patient care prior to any planned nursing and clinical service changes or reductions being contemplated or implemented.

We present the case of FACs as a clear example of how the original intent for FACs has gone astray in practice. Not only will we present recommendations to amend Regulation 965 below, but the experience of FACs also offers a valuable lesson to keep in mind to ensure that legislative language is clear and specific about the structure, function and operation of quality committees in hospitals under Bill 46.

## **RECOMMENDATIONS**

### **1. Amend section 5 in Regulation 965 under the *Public Hospitals Act* and ensure the MOHLTC enforces Regulation 965.**

As noted in the background section, many hospitals do not have functioning and effective Fiscal Advisory Committees. Although aware of the facts, to date the MOHLTC has not enforced this violation of Regulation 965. We believe that FACs are an important part of ensuring quality care in hospitals as this committee is responsible for making recommendations on the operation, use and staffing of the hospital.

We are therefore recommending the following amendments to section 5 in Regulation 965 under *the Public Hospitals Act*:

- address the frequency with which FAC meetings should take place to coincide with the hospital budget cycle but not less than quarterly meetings;
- require that information necessary for meaningful consultation be provided in advance to members of the FAC; and
- require that the FAC make recommendations to the Board and that the Board of a hospital take into account the recommendations of its FAC before making significant decisions affecting the operation, use and staffing of the hospital.

The MOHLTC must put in place inspection processes to ensure that violations of section 5 in Regulation 965 are inspected and that the Regulation is enforced, including board by-laws that provide for the participation of staff nurses in decision-making related to administrative, financial, operational and planning matters in the hospital.<sup>4</sup>

**2. Amend section 7 of Regulation 965 and sections 35 to 37 in the *Public Hospitals Act* to replace the Medical Advisory Committee with an Interprofessional Advisory Committee with representation from frontline staff registered nurses.**

Parallel with the introduction of Bill 46, and as part of the background materials accompanying the legislation, the government amended Regulation 965 to require critical incidents to be reported to the hospital's Medical Advisory Committee, and to create action plans for every critical incident.

Not only does this regulatory change seem to overlap with the mandate of quality committees in Bill 46, but it also clearly raises the issue of the need for a representative Interprofessional Advisory Committee to address critical incidents in the context of collaborative practice.

Further, the Local Health Integration Networks (LHINs) have already recognized the importance of interdisciplinary advice and put in place such committees in their structure.

In addition, the 2007 coroner's inquest into the death of ONA member Lori Dupont, RN, recommended that a review of the *Public Hospitals Act* be "conducted on a priority basis:"

Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superceded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.

We agree that quality patient care is the most important factor and is dependent on care from a range of regulated health professionals. It is time to update hospital committee membership to recognize this fact by extending to an Interprofessional Advisory Committee with representation from frontline staff registered nurses.

**3. Amend Bill 46 to provide clear and specific requirements, rather than in regulation, regarding the composition, structure, function and operation of quality committees in hospitals, and define the terms used related to quality.**

Section 3(1) in Bill 46 provides that every public hospital "shall establish and maintain a quality committee." Further, every quality committee shall report to the hospital board under section 3(3). We find this language very similar to the language in Regulation 965 providing for the mandatory *establishment* of FACs and that FACs *shall* make recommendations to the board. We know this is not taking place in practice in many hospitals. For this reason, we are concerned about the specific nature and operation of quality committees in hospitals.

We note that the "membership, composition and governance" of quality committees is to be provided for in regulations. We find this to be problematic as we are unable to comment on the membership, composition and governance of quality committees at this time.

We recommend that these matters be set out in legislation, and that frontline staff registered nurses (RNs) are represented on Quality Committees because of the daily connection to quality patient care in the work performed by RNs.

In addition, the composition of quality committees is to be set out in regulations made by the Lieutenant Governor in Council and section 16(2) provides for public consultation before making these regulations. At least public consultation is provided for but the composition is not set out in legislation but left for regulation.

However, the Minister of Health and Long-Term Care may make regulations under section 15(c) "governing quality committees...respecting their functions, record-keeping requirements and

reporting relationships and providing for additional responsibilities for quality committees.” Not only do these regulatory matters for quality committees not provide for a specific public consultation process, they are also not set out in legislation in Bill 46. We recommend such matters be set out in Bill 46 to prevent a recurrence of the issues encountered with Regulation 965.

Under section 4, quality committees are to monitor and report to the board on quality issues and on the overall quality of services provided in hospitals with reference to appropriate data, consider and make recommendations to the board regarding quality improvement initiatives and policies, and ensure best practices information supported by available scientific evidence is dispersed to employees within hospitals. However, “quality” or “quality issues” is not defined, “quality improvement initiatives and policies” is not defined, and “best practices information” is not defined.

The SARS experience was a cautionary example of the danger of interpreting “data” and “evidence” too narrowly. Quality reviews should consider “scientific evidence” but should also refer to other forms of evidence or data as appropriate to receive a clear understanding of the overall quality of care within a facility.<sup>5</sup>

Furthermore, as Justice Campbell advised, caution should be exercised when “scientific” evidence is not conclusive. He recommended that the “precautionary principle” be enshrined and enforced throughout the health system. Bill 46 should embrace this concept as a responsibility of the quality committee.

It is difficult to comment on setting up quality committees in hospitals when what constitutes quality is not defined, and the membership, composition, and governance of quality committees are to be developed in regulations, as are additional responsibilities for quality committees, but these additional responsibilities would not be subject to a public consultation process.

As well, section 4(4) provides that quality committees are “to oversee the preparation of annual quality improvement plans.” The objectives of quality improvement plans are not defined.

We recommend that Bill 46 set out clear language, not to be developed in regulations, to define what constitutes quality, quality issues and quality care, and provides for the composition,

structure, function and operation of quality committees in hospitals. Frontline staff RNs must be represented on Quality Committees.

**4. Amend Bill 46 to provide definitions and safeguards in terms of the objectives for and what constitutes quality improvement plans.**

As mentioned, objectives for quality improvement plans are not defined in Bill 46. Section 8 provides that every hospital shall develop a quality improvement plan every fiscal year, and that the quality committee is to oversee the preparation of annual quality improvement plans.

Quality improvement plans are to at least consider the results of patient and employee surveys, data relating to an undefined patient relations process, and critical incident data as well as information related to indicators of quality of health care pursuant to regulations under the *Public Hospitals Act*.

However, we are concerned that the LHINs have been using the language of Hospital Improvement Plans to justify clinical service reductions in hospitals, not based on evidence-based clinical decisions or on improving quality, but in order to reduce expenditures in hospitals and to force hospitals to balance their budgets.

We want to be assured that Quality Committees will indeed be concerned with quality care, not solely the cost of care. We also believe that quality improvement plans should require review of patient and worker health and safety performance. We recommend that Bill 46 provide clear definitions regarding the objectives of quality improvement plans, and prohibitions be set out for hospitals and quality committees from using quality improvement plans to justify cuts to hospital clinical services and frontline clinical positions.

**5. Amend Bill 46 to provide that hospitals and quality committees must not engage in cuts to or substitutions of registered nursing positions in the guise of providing quality care. Quality committees must be able to make recommendations on staffing improvements based on evidence supporting quality care and as part of any quality improvement plan.**

The current context for quality patient care in Ontario is fewer registered nurses per population than other provinces, the elimination of thousands of RN positions and millions of hours of care by registered nurses, and an aging nursing workforce. Yet, current government policies have

not addressed the more than 2,100 nursing positions that have been eliminated over the past twelve months and the elimination of more than 3.6 million hours of care from registered nurses.

Bill 46 purports in section 4 that best practices information on quality issues will be supported by “available scientific evidence.” However, the research evidence showing better outcomes for patients with *more* hours of nursing care is well documented.<sup>6</sup> There is strong evidence linking a nursing staff mix with higher proportions of RNs and lower hospital in-patient mortality rates.

Inadequate nurse staffing directly impacts on quality patient outcomes. Adding one patient to a nurse’s average caseload in acute care hospitals is associated with a 7 per cent increase in failure to rescue (complications), a 7 per cent increase in patient mortality, a 23 per cent increase in nurse burnout, and a 15 per cent increase in job dissatisfaction.<sup>7</sup>

Research findings from numerous additional studies have shown the relationship between higher RN staffing and several positive patient outcomes: reduced hospital-based mortality, hospital-acquired pneumonia, unplanned extubation, failure to rescue, nosocomial bloodstream infections, and length of stay.<sup>8</sup> These positive outcomes for quality care from higher RN staffing are also associated with reduced overall economic costs.

One study by Needleman et al.<sup>9</sup> balanced the costs of increasing nurse staffing in United States hospitals with the associated cost savings that might be achieved by reducing adverse outcomes and length of hospital stays, and avoiding patient deaths. They concluded that raising the proportion of nursing hours supplied by RNs resulted in improved patient outcomes and reduced the costs associated with longer hospital stays and adverse outcomes compared to other options for hospital patient care staffing.

A further study<sup>10</sup> has shown that improved patient care from additional RN staffing that prevents nosocomial complications, mitigates complications through early intervention, and leads to more rapid patient recovery, creates hospital savings and demonstrates the economic value of professional nursing.<sup>11</sup>

Patients are in hospital because they are unstable and unpredictable. The acuity of patients in Ontario hospitals is higher as less acute patients are now being transferred out of hospital into alternate levels of care, such as in the community and other settings. RNs have the right scope

of practice to care for unstable, unpredictable, and high-acuity patients. The research evidence confirms they provide good clinical value and good economic value, and RN staffing results in the provision of quality patient care.

Yet, hospitals in Ontario are ignoring the research literature and eliminating RN positions, not on clinical grounds as measured by positive health outcomes and quality care, but simply as cost-cutting measures to balance their budgets. They say the same number of patients will be cared for by fewer RNs or by other workers. We know from the literature that this will result in more complications, higher costs and higher mortality. A higher RN staffing model is the best overall value for quality patient outcomes.

We recommend that hospital quality committees be prohibited from cutting RN positions as part of any quality improvement plan.

Further, we recommend that quality committees must be able to put forward recommendations related to staffing improvements to provide for quality care as part of any quality improvement plan.

**6. Amend Bill 46 to caution that employee and patient surveys are not sufficiently objective evidence to take action on quality care initiatives.**

Although understanding how patients and staff view their experiences could add an important dimension to evaluating quality in hospitals, satisfaction surveys may also provide little meaningful information, and could potentially subvert real action on quality improvement by being used more as a marketing tool to enhance market share. For example, surveys have been used by long-term care facilities and by other health care organizations in the U.S. as part of their ongoing efforts to avoid regulatory approaches to evaluating quality.<sup>12</sup>

In addition to potential methodological issues with satisfaction surveys, such surveys primarily provide information on subjective experiences of patients with their care, which can be heavily influenced by specific interpersonal experiences rather than an objective assessment of the technical aspects of quality clinical care provided.<sup>13</sup>

We urge the Standing Committee to take into consideration these cautions related to the use of and relying on data from satisfaction surveys.

**7. Amend Bill 46 to define the patient relations process and consider alternative processes to address patient complaints. Extend Freedom of Information legislation to apply to hospitals.**

Section 6 provides that hospitals must have a “patient relations process.” A patient relations process is not defined. If by patient relations process, it is meant a complaints process for investigating complaints from patients, we recommend that consideration be given by the government to the creation of an independent patient advocate or oversight of hospitals by the Ontario Ombudsman to investigate patient complaints.

In addition, we recommend that hospitals be covered under the *Freedom of Information and Protection of Privacy Act* to allow for greater transparency in hospitals in the public interest.

**8. Amend Bill 46 so that details are set out in legislation, not left to be determined in regulations.**

We are concerned about the numerous areas in Bill 46 that are to be set out in regulations. We have made recommendations throughout our submission where details must be in Bill 46, not left to be determined by regulation.

**9. Amend Bill 46 to review and standardize hospital executive compensation, and also link to achieving a culture of safety for patients and staff in addition to achieving quality outcomes.**

Bill 46 provides for some undefined portion of executive compensation in hospitals to be linked to the achievement of performance improvement targets set out in the annual quality improvement plan. How this is to be accomplished is unknown as it is to be provided in regulations.

In addition, provincial variation in and high levels of executive compensation in hospitals is not up for discussion or regulation. We recommend hospital executive compensation should be reviewed and provincial standards be set and enforced by the government.

Further, we recommend that executive compensation should also be linked to the achievement of a culture of safety for patients and staff in hospitals. A healthy and safe working environment is clearly related to safe and quality patient care. Executives must understand and commit to

establishing healthy and safe cultures in their workplaces. Performance improvement targets in section 9 must explicitly include targets to achieve a culture of safety.

**10. Amend Bill 46 to safeguard that the expanded mandate for the Ontario Health Quality Council not be used to delist needed health services currently covered by OHIP.**

We are concerned that the expanded mandate for the Ontario Health Quality Council may be used to justify delisting of needed health services that are currently funded by government and covered by OHIP.

We do support constraints on the overuse or misuse of technological interventions in order to curtail inappropriate treatment and unnecessary costs to the health care system. However, we believe that there should be broad public consultation on any recommendations concerning changes to government funding of health care services and medical devices.

We also believe that it is important to expand the scope of members to include occupational health and safety expertise under section 10(3).

**CONCLUSION**

Quality care is a fundamental concern for nurses. Bill 46 does not define quality or quality issues that are to be reviewed by quality committees, nor the composition of quality committees. These oversights must be rectified in legislation, not provided for in regulation, and include representation by frontline staff RNs on quality committees.

Definitions and safeguards need to be put in place in terms of the objectives for and what constitutes quality improvement plans, and what evidence needs to be considered.

Hospitals and quality committees must not engage in cuts to or substitution of registered nurse positions in the guise of providing quality care. Quality committees must be able to make recommendations on staffing improvements based on evidence to support quality care and as part of any quality improvement plan.

We have also provided cautions related to the use of satisfaction surveys as a measure of quality care, and the limitations of “scientific” evidence and the need to apply the precautionary

principle. Additional recommendations include considering an independent patient complaints process, reviewing and standardizing executive compensation in hospitals while also linking it to achieving a culture of safety in hospitals, and ensuring that the expanded mandate for the Ontario Health Quality Council is not used to delist needed health services currently covered by OHIP.

We respectfully submit our recommendations and request that they be given serious consideration by the Standing Committee so that patients in hospitals receive the quality care they deserve.

## ENDNOTES

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<sup>1</sup> The late Justice Archie Campbell, in his SARS Commission report, wrote: “occupational health and safety protections perform a double duty, safeguarding workers while also shielding patients and visitors....If workers are not protected from health and safety hazards, patients and public are not protected either. It’s that simple.” See *Spring of Fear*. Volume 1e.

<sup>2</sup> “Until this divide is bridged and infection control and worker safety disciplines begin to actively and effectively cooperate, it will be difficult to establish a strong safety culture in Ontario.” Ibid.

<sup>3</sup> See Regulation 965, *Public Hospital Act*, section 4(1)(f) (i) and (ii).

<sup>4</sup> See section 4(1)(f)(i) in Regulation 965.

<sup>5</sup> For example, reports of critical incidents involving patients, worker injury and illness reports, Ministry of Labour orders, prosecution and conviction reports, and patient and caregiver information are forms of evidence that should also be helpful in any review of quality of care.

<sup>6</sup> See the literature cited in Tourangeau, Anne E. et al., “Impact of hospital nursing on 30-day mortality for acute medical patients.” *Journal of Advanced Nursing* 57(1):33, 2007.

<sup>7</sup> See Aiken et al. “Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction.” *Journal of the American Medical Association* 288(16): 1987-1993, 2002.

<sup>8</sup> See, for example, Needleman, et al. “Nurse-staffing levels and the quality of care in hospital.” *New England Journal of Medicine* 346(22): 1715-1722, 2002

<sup>9</sup> Needleman, J., et al. “Nurse staffing in hospitals: Is there a business case for quality?” *Health Affairs* 25(1): 204-211, 2006.

<sup>10</sup> Dall, Timothy M. et al. “The Economic Value of Professional Nursing,” *Medical Care* 47(1):97-104, 2009.

<sup>11</sup> The term “economic value of professional nursing” in this study refers to a monetary assessment of the value of incremental changes in nurse staffing that result in improved quality of patient care. This definition emphasizes the changes in nurse staffing that affect medical costs due to the impact on patient outcomes. Improved patient care that prevents or mitigates complications creates savings. Reduced lengths of recovery and mortality rates have productivity implications.

<sup>12</sup> See the cautions on using satisfaction surveys. Edelman, Tobey S. and Charlene Harrington. *An Analysis of the Shirlee Sharkey Report on Long Term Care Homes Human Resource Issues in Ontario*. Research commissioned by the Ontario Health Coalition, December 18, 2009, pp. 17-18.

<sup>13</sup> Ibid.