Independent Assessment Committee Report

Constituted Under Article 10.1 of the Collective Agreement

between

Cassellholme East Nipissing District Home for the Aged

and

Ontario Nurses' Association

March 2010

Independent Assessment Committee

Cassellholme East Nipissing District Home for the Aged
and
Ontario Nurses' Association

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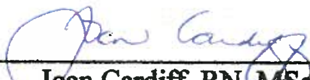
The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by registered nurses working at Cassellholme East Nipissing District Home for the Aged.

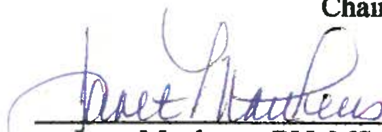
The Complaint was presented to the Independent Assessment Committee in accordance with Article 10.1 of the Collective Agreement between Cassellholme East Nipissing District Home for the Aged and the Ontario Nurses' Association.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Home for the Aged, the Association and the registered nurses working at the Home to prepare and present information and respond to our questions. The attached Report includes a number of unanimously supported Recommendations which we hope will assist all parties to continue to work together, in good faith, to provide optimal care to the residents of Casselholme.

Respectfully submitted on March 31, 2010.



Joan Cardiff, RN, MScN
Chairperson, Independent Assessment Committee



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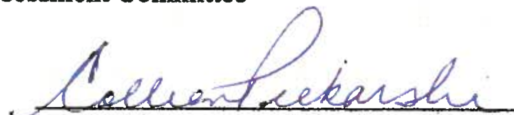

Colleen Piekarski, RN, MScN
Cassellholme East Nipissing District
Home For the Aged Nominee

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SECTION I

INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (IAC) Report is presented in five sections:

- Section I reviews the IAC's jurisdiction as outlined in the Collective Agreement between Cassellholme East Nipissing District Home for the Aged ('Cassellholme') and the Ontario Nurses' Association ('the Association'), outlines the referral of the Professional Responsibility Complaint to the IAC, and presents the Pre-Hearing, Hearing and Post-Hearing processes.
- Section II presents the context of practice relating to the professional responsibility complaint at Cassellholme, summarizes the history leading to the referral of the complaint to the IAC, and reviews the presentations made by Cassellholme and the Association at the Hearing.
- Section III presents the IAC's discussion and analysis.
- Section IV presents the IAC's conclusions and recommendations.
- Section V contains Appendices referred to in the Report.

1.2 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 10.01 of the Collective Agreement between Cassellholme and the Association.

The Professional Responsibility Complaint (PRC) process contained within Section 10.01 sets out the process by which Registered Nurses (RNs) can raise their concerns regarding their perception of excessive workload situations and/or improper resident care practices, and outlines the steps to be followed to address their concerns to the mutual satisfaction of both the RNs and Management.

> *10.01*
> *In the event that the Employer assigns a number of residents or a workload to an individual employee or group of employees, such that she or they have cause to believe that she or they are being asked to perform more work than is consistent with proper resident care, she or they shall:*
>
> *(a) i) Complain in writing to the Director of Nursing within ten (10) calendar days of the alleged improper assignment. The chairperson of the Union Management*

Committee shall convene a meeting of the committee within ten (10) calendar days of the filing of the complaint. The committee shall hear and attempt to resolve the complaint to the satisfaction of both parties.

ii) *Failing resolution of the complaint within ten (10) calendar days of the meeting of the Union Management Committee, the complaint shall be forwarded to an independent assessment committee composed of three (3) registered nurses; one (1) chosen by the Ontario Nurses' Association, one (1) chosen by the Employer and one (1) chosen by a panel of four (4) independent registered nurses who are well respected within the profession. The member of the committee chosen from a panel of independent registered nurses shall act as chairperson.*

iii) *The Assessment Committee shall set a date to conduct a hearing into the complaint within fourteen (14) calendar days of its appointment and shall be empowered to investigate as is necessary, and to make what findings are appropriate under the circumstances. The Assessment Committee shall report its findings, in writing, the parties within twenty-one (21) calendar days following completion of its hearing.*

iv) *It is understood and agreed that representatives of the Ontario Nurses' Association, including the Labour Relations Officer and the Nursing Practice Officer, may attend meetings held between the Home and the Association under this provision.*

v) *Any complaint lodged under this provision shall be on the form set out in Appendix C.*

The IAC's jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper resident care. RN workload is influenced by client factors (e.g. complexity of bio-psycho-social care needs, cultural, emotional and health learning needs) nurse factors (e.g. nurse-resident ratio, roles and responsibilities of the RN and other care providers) and environmental factors (e.g. practice supports, consultation resources, physical environment of practice)[1]. The IAC is responsible for examining all factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

The IAC's jurisdiction ceases with the submission of its written report. The IAC's findings and recommendations are intended to provide an independent, external perspective to assist the RNs, the Association and the Employer to achieve mutually satisfactory resolution to the professional responsibility complaint. The IAC is not an adjudicative panel, and its recommendations are not binding.

1.3 Referral to the Independent Assessment Committee

Cassellholme and the Association negotiated their first Collective Agreement in March 2005. Consistent with Collective Agreements between the Association and employers in hospital, long term care and community settings, the Agreement included language regarding professional responsibility, referred to in Section 1.2 above.

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[1] College of Nurses of Ontario: *Practice Guideline: Utilization of RNs and RPNs*, 2009.

RNs at Cassellholme began to submit Professional Responsibility Workload Report Forms (PRWRFs) shortly after the first Collective Agreement was negotiated. From May 2005 through early January 2010, 225 PRWRFs were submitted.

Cassellholme, the Association and the RNs have discussed the issues identified on the PRWRFs at Union-Management meetings since 2005 and have been able to resolve a number of issues. However, from the RNs' and the Association's perspective, a significant number have continued to remain unresolved. The Association formally referred the unresolved issues through a Letter of Complaint to the IAC Chairperson on October 6, 2009 (Appendix 1).

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing:

In accordance with Section 10.01 (a) ii), Cassellholme and the Association identified their Nominees to the IAC. The Chairperson received notification of the Association Nominee, Janet Matthews, on October 6, 2009, and notification of the Cassellholme Nominee, Colleen Piekarski, on November 24, 2009.

The IAC conducted its initial communications, including selection of dates for the Hearing, by email between November 30 and December 5, 2009. The IAC Chairperson wrote to the Association and Cassellholme on December 6, 2009 to confirm the date and location of the Hearing, and provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested Cassellholme and the Association to submit their Hearing Brief and associated exhibits to the Chairperson by January 22, 2010 (Appendix 2).

The IAC held its first meeting by teleconference on December 15, 2009. Following introductions, the IAC discussed the logistics associated with the Hearing and the process for review of the Submission Briefs, reviewed the draft Hearing Agenda submitted to the Association and Cassellholme on December 6, 2009, and planned the pre-Hearing meeting.

The IAC Chairperson received the Association Brief on January 22, 2010 and the Cassellholme Brief on January 26, 2010, and distributed the Briefs and Exhibits by courier to all parties on January 27, 2010. The Association provided additional information to supplement their Brief on January 28, 2010; this was distributed to all parties the same day.

The IAC held a Pre-Hearing Meeting in North Bay on February 4-5, 2010. The IAC reviewed the anticipated process of the Hearing, discussed the Hearing Briefs and Exhibits provided by Cassellholme and the Association, determined requirements for additional information, and identified the key issues for exploration at the Hearing. Following this meeting, on February 6, 2010, the IAC Chairperson wrote to Cassellholme to request that specific additional information be provided by February 10, 2010, and jointly to Cassellholme and the Association to request that arrangements be made to enable one of the four full-time RNs working 8-hour shifts to attend the Hearing (Appendix 3).

The IAC met briefly on the morning of February 9, 2010 to confirm the questions/issues for focus on the Site Tour.

The IAC toured Cassellholme from 10:00 – 12:00 hours on Tuesday February 9, 2010. The Tour included a detailed walk-through of

- the four resident care units,
- the basement storage area (including the Nursing Storage Room, Housekeeping Storage, Maintenance Shop, Boiler Room, Morgue and a meeting room and classroom) and
- the three hallways on the main floor:
  - the 'main hallway' (including the kitchen, Apple Dining Room, Clinical Services Department offices, Schedulers' office and the Reception/Gift Shop),
  - the 'back hallway' (including the Staff Lunchroom and Community Support Services), and
  - the 'administration hallway' (including offices of the Administrator, Finance, Human Resources, Volunteers, Pastoral Care etc as well as the Auditorium).

The Site Tour was jointly conducted by the following:

On behalf of the Association:
Christine Byrnes, RN Supervisor, Bargaining Unit President
Christine Hildreth, RN Supervisor
Jo Anne Shannon, Professional Practice Specialist

On behalf of Cassellholme:
Ward Jones, Consultant
Cindy Ross, Director of Clinical Services
Cheryl Sheppard, Manager of Clinical Standards

1.4.2 Hearing

The Hearing convened at 1300 hours in the Garden Room of Cassellholme. In accordance with the Agenda (Appendix 4), the Hearing was held over three days:

February 9, 2010:	1300 – 1630 hours
February 10, 2010:	0900 – 1200 hours 1300 – 1630 hours
February 11, 2010:	0830 – 1300 hours

The Participants and Observers who attended the Hearing are listed in Appendix 5.

February 9, 2010

The IAC Chairperson opened the Hearing at 1300 hours. Following introduction of the IAC Committee members and round-table introductions of the Association and Cassellholme participants, the IAC Chairperson reviewed the following:

- the IAC Hearing process, including the pre-Hearing phase, and the anticipated organization and flow of the Hearing over the three days;
- the jurisdictional scope of the IAC, including the purpose of the IAC, the scope of its recommendations, and the IAC process as outlined in Section 10.01 of the Collective Agreement; and

- the ‘ground rules’ for the Hearing, to facilitate a respectful and constructive environment.

Jo Anne Shannon, Professional Practice Specialist with the Association, and Christine Byrnes, Bargaining Unit President, presented the Hearing submission on behalf of the Association. Following a 20 minute break, Ward Jones, Consultant with Cassellholme, presented the Hearing submission on behalf of Cassellholme. The IAC Chairperson adjourned the Hearing at 1630 hours.

The IAC met from 1630 – 1830 hours, to review, discuss and synthesize the information provided, and to begin to identify issues for which further/more detailed information was required.

February 10, 2010

The IAC Chairperson opened the Hearing at 0900 hours. Ward Jones, Consultant with Cassellholme, provided the Response on behalf of Cassellholme. All members of the Cassellholme team participated in the discussion following. After the lunch break, Jo Anne Shannon, Professional Practice Specialist, provided the Response on behalf of the Association. All members of the Association team participated in the discussion following. The IAC Chairperson adjourned the Hearing at 1630 hours.

The IAC met from 1700 – 2030 hours to review and synthesize the information provided and develop questions to clarify key issues.

February 11, 2010

The IAC Chairperson opened the Hearing at 0830 hours. New participants at the Hearing were introduced. The IAC explored the issues for which the Committee required further clarification and discussion with both the Association and Cassellholme in an interactive Question and Answer session. All Hearing participants actively participated.

At the conclusion of the Hearing, the IAC Chairperson:

- thanked the participants for their engagement in and commitment to the Hearing process, and for their active participation throughout the Hearing;
- noted that the IAC recognizes the sensitivities often experienced with open and honest dialogue, and reiterated the IAC’s belief that the opportunity for discussion during the Hearing would help all parties to move forward;
- reconfirmed that the IAC’s Report and Recommendations are intended to provide an independent external perspective to aid in the resolution of outstanding issues, and although the recommendations are non-binding, it is hoped that they will provide a solid foundation on which to build; and
- confirmed that the IAC’s Report would be distributed by courier on March 19, 2010.

The IAC Chairperson concluded the Hearing at 1315 hours.

<u>1.4.3 Post Hearing</u>

Between the closure of the Hearing on February 11, 2010 and the submission of the IAC Report on March 19, 2010, the IAC held four teleconferences and two face-to-face meetings. Due to a death in the Chairperson's immediate family, submission of the IAC Report was delayed to March 31, 2010.

The IAC met immediately following the IAC Hearing, from 1330 – 1445 hours on February 11, 2010, to debrief the discussion and key issues identified.

The IAC reviewed Draft I of the report by teleconference from 1800 – 2015 hours on February 25, 2010.

The IAC held a face-to-face meeting from 1400 – 1800 hours on March 4, 2010 and 0900 – 1600 hours March 5, 2010 to review Draft II, and to discuss the findings and proposed recommendations in depth. Following this meeting, the IAC Chairperson wrote to Cassellholme on March 14, 2010 to request clarification of a number of issues (Appendix 6).

The IAC met by teleconference from 1400 – 1630 hours on March 18, 2010 to review Draft III, reviewed Draft IV by email and met by teleconference from 0800 – 0930 hours on April 1, 2010 to review Draft V. The IAC reviewed the final draft of the Report by teleconference on April 5, 2010.

The Final Report was submitted to the Association and to Cassellholme on April 7, 2010 by courier.

SECTION II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT

2.1 Context of Practice

2.1.1 Ownership/Governance

Cassellholme East Nipissing District Home for the Aged is a Municipal not-for-profit Home for the Aged located in North Bay, Ontario. Owned and operated by nine Municipalities in the East Nipissing District (the City of North Bay, the Town of Mattawa, and the Townships of Bonfield, Calvin, Chisholm, East Ferris, Mattawan, Papineau-Cameron and South Algonquin), Cassellholme is governed by a 7-member Board of Management made up of elected municipal officials appointed by the participating municipalities. Cassellholme operates in accordance with the *Homes for the Aged and Rest Homes Act,* and is accredited under the auspices of Accreditation Canada, with its most recent accreditation achieved in 2008.

2.1.2 Resident Care Units

Cassellholme first opened in 1925. The present Home, officially opened in 1962, has undergone a number of major renovations over the past 48 years. Cassellholme provides care to 240 residents on three floors:

1st floor:	Apple	◆50 residents		
	Maple	◆47 residents		
2nd floor:	Birch	◆71 residents	North wing	▪36 residents
			West wing	▪35 residents, including Cherry Lane (18 bed secured unit)
3rd floor:	Willow	◆72 resident	North wing	▪36 residents (all female)
			West wing	▪36 residents

In early February 2010, Cassellholme received notification from the Ministry of Health and Long Term Care (MOHLTC) that it has been approved for redevelopment in Phase 1 of the MOHLTC Long Term Care Renewal Strategy. Cassellholme anticipates that this funding will enable significant improvements in the physical infrastructure by 2011.

Other than the secured unit, Cherry Lane, levels of care (see Section 2.1.3) are integrated across the facility, and the care needs of residents are fairly similar on all four resident care units.

The majority of residents live in semi-private rooms[2]. The rooms on the 1st floor Units, Apple and Maple, are smaller than those on the 2nd and 3rd floor; the bathroom in each room has a sink and toilet but cannot accommodate a wheelchair. The rooms on the 2nd floor Birch and 3rd floor Willow Units, which were added during a later renovation, are large and bright. These rooms are configured so that both residents have direct access to the window, and the bathrooms enable wheelchair entry. Currently 38 of the rooms throughout the facility are equipped with ceiling lifts.

Residents eat in dining rooms located throughout the facility. Although the goal is for residents to eat in a dining room on their Unit, this is not always possible due to space constraints. Therefore, selected residents from the 2nd floor are brought to a small dining room on the Apple Unit for meals; residents from Apple eat in a dining room located off the Unit on the main hallway. Residents in the 18-bed Cherry Lane eat within the secured unit, but as the dining room is too small to accommodate all 18 residents, some eat at tables in the common room area. Cassellholme has a large kitchen, and prepares all resident meals 'from scratch'[3].

Each Unit is configured with resident rooms on the exterior and workrooms (tub rooms, storage rooms, medication rooms and nursing station) in the interior. The size of the nursing stations varies; those on Apple and Maple are smaller than those on Birch and Willow. There are three computers on each unit, two in the Nursing Station and one in the Nursing office (formerly Nurse Manager's office).

A large Physiotherapy Room is located on the Apple Unit. Residents who are unable to easily access the Physio Room receive physiotherapy in their rooms.

Unit supplies (e.g. dressings, catheters, other care supplies) are located in the Supply Room on each Unit; these are stocked from the bulk supplies kept in the Nursing Storage Room in the basement. Although the Unit Supply rooms viewed by the IAC appeared to be somewhat disorganized, with no clear delineation between 'clean' and 'dirty', the basement Nursing Storage Room is well organized, with supplies and medications clearly marked, boxes put away etc. Resident medications are kept in the medication carts (personal compliance packs), Unit Medication Room (stock medications) and the Nursing Storage Room (bulk supplies of stock medications).

Unit supplies and stock medications are re-stocked on each Unit on Thursdays, based on the restocking requirements identified by the RPN on Wednesday night. When additional supplies are required throughout the week, the RN Supervisor working the 12-hour Day / Night shift, who carries the master keys for the building, is responsible to ensure that these are obtained and appropriately delivered. Medications are delivered from a local pharmacy each afternoon; the RN Supervisor is responsible to ensure that the medications are transported to the correct Unit / Storage Room.

2.1.3 Levels of Care Classification

Across Ontario, the MOHLTC Resident Classification System has been conducted annually since 1992 to determine needs-based government funded nursing and personal care. Based on

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[2] All residents live in semi-private or private rooms; there are no 3 or 4-bed ward rooms.
[3] Cassellholme also prepares the means distributed through the Meals-on-Wheels Program in North Bay.

documentation provided by the long-term-care facility, residents are classified into one of seven levels (A through G) reflecting their nursing and personal care requirements relating to

- activities of daily living (ADL): eating, toileting, transferring and dressing;
- behaviours of daily living (BDL): potential for injury to self or others and ineffective coping; and
- continuing care level (CCL): urinary and bowel continence.

Levels A and B represent ‘light care’, C, D and E represent ‘medium care’, and F and G represent ‘heavy care’[4]. The Case Mix Measure (CMM) reflects the total care requirements of the residents in the facility. This CMM is compared to those of other facilities in the province to determine the facility’s Case Mix Index (CMI). A CMI below 100 indicates a higher number of lighter care residents than the provincial average.

The CMM and CMI at Cassellholme have increased substantially over the past six years, as indicated in Table 1. The IAC was unable to determine the extent to which this increase is based on improved documentation, as suggested by Cassellholme, and/or the extent to which it reflects an actual change in resident care needs, as suggested by the Association. With a CMI of 96.41, Cassellholme residents’ care needs are slightly below those of the total provincial average[5], and are consistent with the norm for Municipal not-for-profit Homes for the Aged[6].

Table 1: Cassellholme Case Mix Measure / Case Mix Index

Year	CMM	CMI	Residents in Classifications A-D	Residents in Classifications E-G
2002	75.25	84.70	47%	53%
2005	85.34	91.37	30%	70%
2008	96.45	96.41	12%	88%

[4] MOHLTC Policy 0807-01, December 1993.

[5] The total provincial average includes municipal homes (not for profit), charitable homes (not for profit) and nursing homes (for profit).

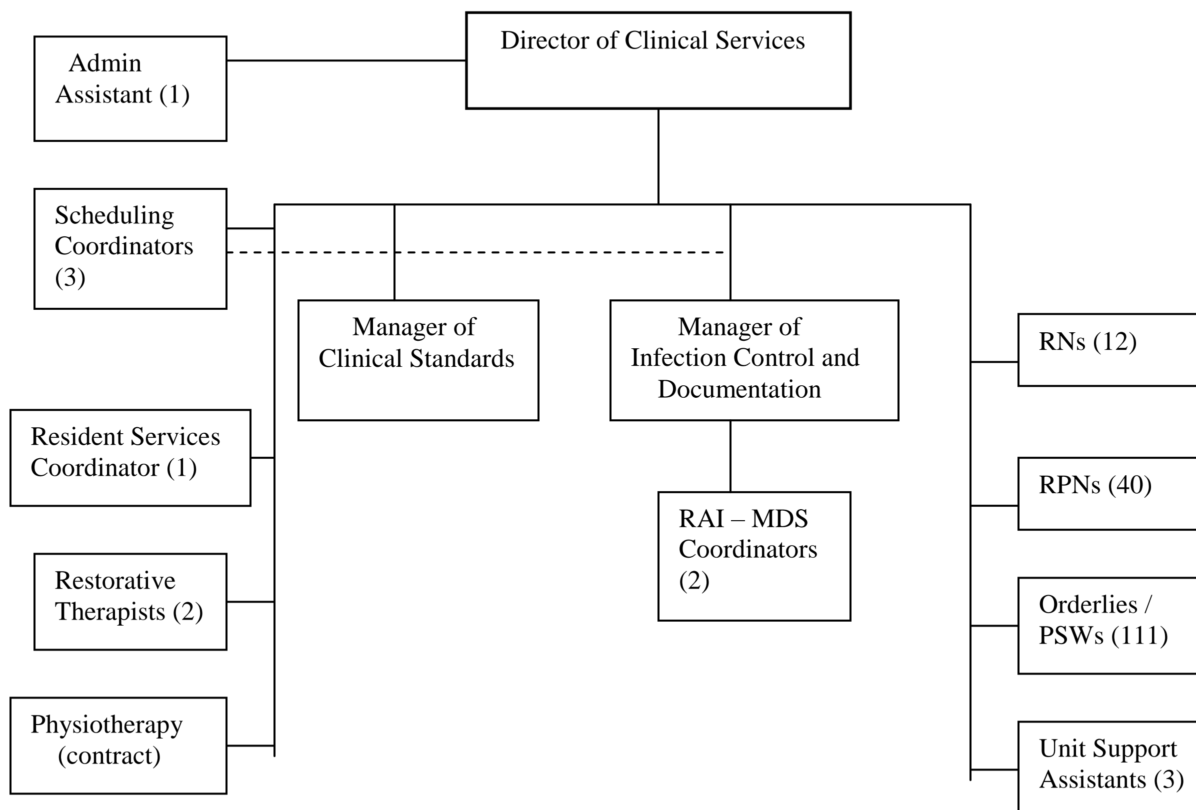
[6] In 2005, the Ontario Association for Not for Profit Homes and Services for Seniors (OANHSS) reported that the average CMI for Municipal not-for-profit Homes was 96.52. (HS 06-025 Long Term Care – Nursing & Personal Care – CMI Results.doc).

2.1.4 Staffing

2.1.4.1 Nursing Leadership

The Director of Clinical Services is one of four senior managers reporting directly to the Administrator[7], and is responsible for scheduling, resident services, restorative therapy, physiotherapy, the RAI assessment system and the provision of resident care (Diagram 1)

Diagram 1: Nursing Leadership Organizational Chart[8]



As noted in Diagram 1, all of the 177 staff members within the Clinical Services portfolio, except the two the RAI-MDS Coordinators, have a direct reporting relationship to the Director. The organizational chart indicates that the two Managers reporting to the Director do not have line accountability for the RNs, RPNs, PSWs and Unit Support Assistants. However, in practice, the two Managers and Director work as a leadership team; for example, all three have direct involvement in performance issues / discipline of regulated and unregulated care provider staff.

[7] The senior management team is comprised of the Administrator, Director of Clinical Services, Manager of Human Resources, Director of Finance and Associate Administrator, who is responsible for Nutrition/Food Services, Housekeeping/Laundry, Maintenance, Activities and Community Support Services.
[8] Chart drawn from Cassellholme Organizational Chart dated March 2009, provided to the IAC by Cassellholme.

2.1.4.2 Resident Care Staffing Schedule and Assignment

Resident care at Cassellholme is provided by RNs, RPNs and PSWs. The RPNs and PSWs work 8-hour shifts, and the RNs work a combination of 8-hour and 12-hour shifts. The current status of these positions is indicated in Tables 2 and 3.

Table 2: Cassellholme Resident Care Staffing: Weekday

Time	RN Supervisor	RPN	PSW	Total
Days	0700 – 1400 4 3 x 8hr 1 x 12hr	0700 – 1500 9	0700 – 1500 28	0700 – 1400 41
	1400 – 1500 5 4 x 8hr 1 x 12hr			1400 – 1500 42
Evenings	1500 – 1900 2 1x 8hr 1x 12hr	1500 – 2300 8	1500 – 2300 19	1500 – 1900 29
	1900 – 2200 2 1 x 8hr 1 x 12hr			1900 – 2200 29
	2200 – 2300 1 1 x 12hr			2200 – 2300 28
Nights	2300 – 0700 1 1 x 12hr	2300 – 0700 4	2300 – 0700 6	2300 – 0700 11

Table 3: Cassellholme Resident Care Staffing: Weekend

Time	RN Supervisor	RPN	PSW	Total
Days	0700 – 1000 2 2 x 12hr	0700 – 1500 8	0700 – 1500 28	0700 – 1000 38
	1000 – 1500 3 3 x 12 hr*			*1000 – 1500 39**
Evenings	*1500 – 1900* 3 3 x 12 hr*	1500 – 2300 8	1500 – 2300 19	*1500 – 1900 30**
	1900 – 2200 2 2 x 12 hr*			*1900 – 2200 29**
	2200 – 2300 1 1 x 12 hr			2200 – 2300 28
Nights	2300 – 0700 1 1x 12hr	2300 – 0700 4	2300 – 0700 6	2300 – 0700 11

** The 1000 – 2200 12-hour day shift is on the master rotation, but is rarely filled. Therefore, from 0700 – 1900, there are usually only two, and from 1900 – 2200 only one, RN Supervisor(s) in the building.*

There are a total of 163 care provider staff within the Clinical Services Department:

RN Supervisor:	8 Full-time 4 Regular Part Time (RPT) (currently 2 positions are vacant)		
RPN:	24 Full-time 16 Part-time	PSW:	58 Full-time 53 Part-time

The assignment of the staff varies:

- The RPNs and PSWs are assigned to a specific unit. As of February 22, 2010, the full-time RPNs work permanent shifts on their designated units; the part-time RPNs will continue to work rotating shifts on their designated units. The RPNs and PSWs work 8-hour shifts.

- The RN assignment depends on the schedule worked:
  - Four (4) full-time RN Supervisors work 8-hour shifts and are assigned to a specific Unit; each works three weeks of Days (0700 – 1500) and one week of Evenings (1400 – 2200) on her Unit per month.
  - Four (4) full-time and four (4) part-time[9] RN Supervisors work 12-hour shifts and do not have a permanent Unit assignment. Monday to Friday, the 12-hour RN Supervisor working Days (0700 – 1900) works from 0700 – 1400 on the Unit where the 8-hr RN Supervisor is working Evenings; when the 8-hr RN comes in at 1400 and assumes responsibility for her Unit, and the 12-hour RN Supervisor moves to a different Unit. For example:
    - If the 8-hr RN Supervisor assigned to Maple is working Evenings, the 12-hour RN Supervisor will be based on Maple from 0700 – 1400.
    - At 1400, the Evening 8-hour RN Supervisor will assume accountability for Maple; at 1500 she will receive report from the 8-hr RN Supervisor on Apple, and will cover both 1st floor units until 2200.
    - At 1400, the 12-hour RN Supervisor leaves Maple; she will obtain report from the Day 8-hour RN Supervisors on Birch and Willow, and assume accountability for these units until 1900.
    - At 1900, the 12-hour RN Supervisor working Nights will assume accountability for Birch and Willow when the RN Supervisor who worked 12-hour Days leaves, and at 2200 will assume accountability for Maple and Apple when the RN Supervisor who worked 8-hour Evenings leaves.

2.1.4.3 Scheduling Process

The schedule for the RPNs and PSWs is developed by the Schedulers, who cover the hours 0600 –1800 Monday to Friday[10], and 1000 – 1400 Saturday and Sunday. The schedule is developed and posted in accordance with the CUPE Collective Agreement. The Schedulers are responsible to replace shifts if an RPN or PSW is absent due to illness, leave of absence, vacation etc. If the shift must be replaced when the Scheduler is not available (such as replacement of a Saturday Day shift on Friday evening, or replacement of a Night shift during the evening Monday to Friday), the RN Supervisor is responsible for calling in a replacement in accordance with

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[9] Two (2) of the RN part-time positions were vacant at the time of the IAC Hearing.

[10] One Scheduler works 0600 – 1400 and the other 1000 – 1800 Monday to Friday, resulting in a four-hour overlap (1000 – 1400) in coverage.

seniority provisions in the CUPE Agreement. RN Supervisors have the authority to authorize premium pay (overtime).

The Director of Clinical Services' Administrative Assistant develops the RN schedule in accordance with the ONA Collective Agreement. Full-time and part-time RNs place requests for days off (i.e. vacation) on a Request Sheet. The part-time RNs also identify additional tours that they would be interested in working above their '45 hours in two weeks' Regular Part-Time (RPT) commitment, and the shifts for which they are not available, on the Request Sheet. The Administrative Assistant picks up the Request Sheet two weeks prior to the posting of the next schedule, and develops the schedule.

There are no casual RNs and the four RPT RN positions are fully committed on the master rotation (i.e. their scheduled shifts on the master rotation fill the 45-hour commitment). Therefore, covering absent shifts is a major challenge.

- When a shift requires covering (e.g. sick call), the shift is first offered (at straight time) to a RPT RN Supervisor. If no RPT RN Supervisors are available, the shift is then offered (at premium time) to a full-time RN Supervisor. If no-one is available, the shift remains uncovered and the nurses 'work short'.
- If there are multiple requests for the same day, the shift off is given to the person with highest seniority if a replacement is available. If there is no replacement at either regular time or premium time, the request is denied.
- In the summer, there has been a 'gentlewomen's agreement' between Cassellholme and the Association that the RNs may work one position short on Days, in order to grant summer vacation.

When an RN Supervisor shift requires coverage on short notice (i.e. sick call), the Administrative Assistant finds a replacement; in her absence (evenings, nights and weekends) the RN Supervisor is responsible for doing so.

Cassellholme maintains a number of statistics regarding scheduling, using the following categories:

- ABS : -absent with approval
- BOAS: -booked off assigned shift (staff member booked for shift, but called in at last minute to say she/he could not come in, due to issues such as 'babysitter didn't come', 'car broke down')
- CL: -compassionate leave
- EMRG: -approved emergency day combined with unapproved emergency days
- LOA: -leave of absence
- NAV: -not available for work (due to working at a second job)
- NS: -no show (staff member booked for shift, but did not arrive)
- Sick days combined: paid sick days, unpaid sick days, unpaid sick days not scheduled
- UB: -union business
- UN: -union negotiations
- WSIB: -workplace safety insurance board / modified work

Indicating 'NAV' on the Request Sheet means that the RN Supervisor will not be called on that day (i.e. to fill an open shift); Cassellholme expects that 'NAV' will be used only when the RN has another job or is unable to work due to being on vacation, sick leave, union business etc. This has caused some consternation among the part-time staff, who believe that they should have the right to indicate days/shifts when they are not available due to personal reasons (work-life balance being a key reason for choosing to work part-time).

Cassellholme also keeps track of 'unwilling to work' statistics, that is, when an RN Supervisor was offered an extra shift and refused it.

2.1.4.4 Absenteeism

Absenteeism, and the related replacement of shifts, is a challenge at Cassellholme. The data provided by Cassellholme indicated that during 2009, the number of days per month that the RNs were at 'full strength' ranged between 1% and 45%. As indicated in Table 4, the RNs at Cassellholme 'worked short' at least 1 RN position per day almost 50% of the time. The number of hours of paid overtime[11] was highest in September and October.

Table 4: RN Staffing: 'Full Strength' versus 'Working Short'

2009: Month		'Full strength'		Short 1 RN Shift/Day		Short 2 RN Shifts/Day		Short 3 RN Shifts/Day		Short 4 RN Shifts/Day		# Hours Overtime Incurred
		Days	%	Days	%	Days	%	Days	%	Days	%	
January	31 days	6	*19*	15	*48*	10	*32*					80
February	28 days	9	*33*	17	*60*	2	*7*					105
March	31 days	8	*26*	14	*45*	9	*29*					54.5
April	30 days	14	*45*	12	*40*	4	*3*					35.5
May	31 days	14	*45*	10	*32*	6	*20*	1	*3*			68
June	30 days	3	*1*	20	*66*	7	*23*					71
July	31 days	4	*13*	10	*32*	16	*52*	1	*3*			109.5
August	31 days	7	*23*	22	*71*	2	*6*					121
September	30 days	10	*33*	18	*60*	2	*7*					169
October	31 days	6	*18*	16	*53*	6	*20*	2	*6*	1	*3*	180
November	30 days	10	*33*	12	*40*	6	*20*	2	*7*			127
December	31 days	11	*35*	14	*45*	6	*20*					3

[11] As per the Collective Agreement, shifts that have been changed after the schedule was posted are paid at a premium time rate; therefore, the overtime hours include 'extra shifts' worked above the regular full-time or RPT commitment, and the rescheduled shifts paid at premium rate.

2.1.4.5 Sick Time

In 2009, there was a significant difference in the sick time between the full-time RN Supervisors working 8-hour shifts from those working 12-hour shifts, and between full-time and part-time nurses, as indicated in Table 5. Full-time RN Supervisors working 8-hour shifts had 61% of the total hours of paid sick time, versus 36% for those working 12-hour shifts; the part-time RN Supervisors accounted for 80% of the unpaid sick time.

Table 5: RN Supervisor Sick Time (2009)

Shift	Paid Sick Days		Unpaid Sick Days		'Sick Not Scheduled'[12]		Total Hours Paid Sick Leave		Total Hours Unpaid Sick Leave	
	#	%	#	%						
Full-time 8hr	76	*70*	8	*18*	-	-	608	*61*	64	*13*
Full-time 12 hr	30	*28*	3	*6*	4	*50*	360	*36*	36	*7*
Part-time 12 hr	2	*2*	34	*76*	4	*40*	24	*3*	408	*80*
Total	108	*100*	45	*100*	8	*100*	992	*100*	508	*100*

2.1.5 RPN Scope of Practice

Cassellholme has made considerable effort over the past two years to develop the RPN role to include a full scope of practice. An educator from Canadore College developed a series of learning modules, which formed the basis for self-directed and didactic learning:

- Injections
- Physical Assessment: inspection, auscultation, palpation, percussion
- Physical Assessment: respiratory, cardiovascular,
- Physical Assessment: abdomen, extremities, head to toe assessment
- Documentation.

The RPNs are now responsible for the administration of all medications, including narcotics, as well as all treatments, transcription of physician orders, and development/updating of care plans. During the Hearing, the RN Supervisors clearly indicated to the IAC that the growth in many of the RPNs has been significant: they are demonstrating more initiative, are more confident in their assessment skills, have an improved understanding of how and when to collaborate with the RN etc., all of which is directly benefiting resident care. The next planned step is to integrate the RPNs into MD Rounds, and to continue to develop their knowledge and confidence with respect to teaching and mentoring the PSWs with whom they closely work.

[12] The IAC was unable to determine the meaning of 'sick not scheduled'.

2.1.6 MOHLTC Compliance Standards / Audits

The MOHLTC Compliance Management Program monitors all long-term care homes in Ontario on an ongoing basis, and inspects their performance at least once a year to ensure they comply with provincial legislation, regulations, standards and policies. During the site visit, the Compliance Advisor looks to ensure that the facility is operating according to its service agreement, relevant legislation and regulations and the standards outlined in the program manual for long-term care homes.

The 2008 Annual Review conducted on June 16-18, 2008 identified nine unmet standards:

A1.11 (x2): *Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse,* and
Every resident has the right to be properly sheltered, fed, groomed and cared for in a manner consistent with his/her needs …. as evidenced by lack of appropriate dietary interventions, slings left in place under residents, lack of mouth care, residents exposed with no action taken, 224 missing signatures relating to provision of care June 1-18 on six audited 'resident care records';

B1.6: *Each resident's care and service needs shall be reassessed at least quarterly and whenever there is a change in the resident's health status, needs or abilities*….as evidenced by lack of bowel, bladder, pain, heat risk, smoking, head injury assessments and/or reassessments, lack of nursing quarterly and interdisciplinary assessments;

B3.41: *Each resident who requires assistance in repositioning shall be turned or repositioned at least every two hours while he or she is awake*….as evidenced by residents not being repositioned for extended periods of time;

C1.17: *Each resident shall receive medication and treatment as ordered by the physician, unless the resident refuses*…..as evidenced by residents observed to not receive meds as ordered, narcotic wastage not cosigned, 104 missing signatures on resident's treatment records;

C1.8: *The use of allocated funding to provide the numbers and levels of nursing staff to provide personal nursing care and treatments to residents*

M2.2: *Each program and service within the Home shall be included in the program for monitoring, evaluating and improving quality*…..as evidenced by the number and severity of unmet criteria in the 2008 review;

M3: *There shall be co-ordinated risk management activities designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the Home*….as evidenced by inappropriate application of restraints, unlocked/unattended medication carts, unsupervised tub room, lack of effective documentation of incident reports or submission of Critical Incident Reports to the MOHLTC, lack of availability of medical progress notes/admission histories/physicals, inconsistent referral of residents with ongoing behaviours;

P1.23*:* *Hot foods shall be served to residents at a minimum of 60 degrees Celsius, cold foods shall be served at a maximum of 5 degrees Celsius, excluding tube feedings*…..as evidenced by lack of monitoring of food temperatures.

In order to address the identified unmet standards, Cassellholme developed a comprehensive series of audits. These were developed by the Manager of Clinical Standards and Director of

Clinical Services, and were specifically directed towards the issues identified by the Compliance Advisor. The vast majority of audits were completed by the RN Supervisors[13]:

- Daily: Toileting, Repositioning, Restraint Release, Resident Care, Resident Room and Dining Room audits;
- Weekly: MARs, TARs, Pain, Flow Sheet, Wound Assessments (with RPN), Restraint Sheets, Posey select, Call bell/24 hour observation sheets, and Skin Assessment for admissions, LOA and hospital readmission audits;
- Monthly: Wound Evaluation, Restraint Usage, Resident Weight, Therapeutic Mattress, Safety and Night Rounds audits;
- Quarterly: Pain Assessment, Smoking, Continence, Progress Notes, and Skin Assessment (Braden Scale Tool) audits.

As indicated in Cassellholme's Corrective Plan of Action submitted to the MOHLTC, the RN Supervisors were expected to follow up with identified issues. For example, "RNs to complete a newly developed audit tool that will be done weekly on MARs and TARs for missing signatures. RN then to address staff who are not compliant with a written notice that may lead to disciplinary action. Audit results and RN actions to be directed to the Manager of Clinical Standards monthly".[14]

The 2009 Annual Review was conducted on August 24-28, 2009, and identified only two unmet standards:

A1.11 (2) *Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his/her needs*…..as evidenced by lack of provision of personal care, inappropriate treatment of constipation, resident falls;

B.1: *A municipality/ies maintaining and operating a Home/Joint Home and the Board of Management of a Home shall ensure that the requirements of each resident of the Home/Joint Home are assessed on an ongoing basis*….as evidenced by lack of appropriate assessments re diabetic care, falls, progressive deterioration of resident, lack of appropriate follow-up with physician re infection etc.

Over the course of the past two years, the audit tools have been refined, the numbers of audits have been decreased, and specific accountability for audit completion has been more clearly articulated. As of January 2010, RN Supervisors are expected to complete the following:

8-hour RN:	Daily:	·Resident Care, Resident Room
	Weekly:	·Wound Assessment (with RPN)
	Monthly:	·Restraint audit, Therapeutic Mattress, Resident Weight, Head to Toe skin assessment (admission/readmission) and Skills Training
12-hour Day RN:	Daily:	·Dining Room Lunch Audit (one Dining Room per day)
	Weekly:	·MARs, TARs and Injection Books (one unit per week), Restraint Flow Sheets (one group book each unit),

[13] Audits were also completed by RPNs (Daily: Evening Care; Weekly: Wound Assessment (with RN); Monthly: Wound Stats), by the Dining Room Monitor (Daily: Food & Fluid Sheets, Dining Duties) and by Unit Support Assistants (Daily: Equipment Cleaning Schedule; Weekly: Tidiness of Unit Rooms, Utility, Tena, Linens, Tubs, Nursing Station; Quarterly: Restraints).

[14] Cassellholme Plan of Corrective Action re 2008 Annual Review, pg 13.

Flow Sheets (one group book each unit)
Monthly: ▪Safety Audit (each unit once per month)

12-hour Night RN: ▪3-Month drug review

In addition, the RNs and RPNs are to complete quarterly the RAI, RAP, Care Plan and the Medication Reconciliation Record.

2.2 Development of the Professional Responsibility Complaint

As noted in Section 1.3, Cassellholme and the Association have been working together to address Professional Responsibility Complaints since their Collective Agreement was first initiated in March 2005. A Professional Practice Advisor has been actively involved since 2006.

PRWRFs have been filed consistently since 2005 (Table 6)

Table 6: PRWRFs Submitted 2005 - 2009

Year	# PRWRFs
2005	14
2006	20
2007	50
2008	86
2009	59

When the Collective Agreement was first initiated, three Nurse Manager positions outside of the bargaining unit worked 8-hour days Monday to Friday and the remaining RNs (full-time and part-time) worked 12 hour shifts (2 RNs 0700 – 1900; 1 RN 1900 – 0700).

The Cassellholme Management Restructuring Report, commissioned by Cassellholme, was completed in March 2006 by FSC International. The Restructuring Report identified role confusion between the Nurse Manager and RN positions, with the Nurse Manager having more of a clinical role in assessments than 'a governing role that assumes more of a unit or home management approach'[15]. Following the Restructuring Report, it was reported at the March 21, 2006 Union-Management Meeting, and reinforced in an email between Cassellholme and the Association in May 2006[16], that the Nurse Manager's role was "80% clinical"[17].

[15] Cassellholme Management Restructuring Report, completed by FSC International, March 2006, pg 7.
[16] Email from Shani Giroux (Human Resources Manager Cassellholme) to Mariana Markovic (Professional Practice Specialist, ONA) May 17, 2006.
[17] This specific breakdown of 80% clinical / 20% administration was not included in the Restructuring Report document received by the IAC. The IAC assumes that the percentage breakdown was provided in debriefing discussions between Cassellholme and the FSC International consultants.

In May 2006, the Association recommended that an additional 12-hour position Monday-Sunday be created, and stated "on the question of the unionization of the role of the Nurse Managers it makes for a good approach as 80% of their work is nursing"[18]. A meeting was held on June 7, 2006 to discuss this proposal, from which a Letter of Agreement between Cassellholme and the Association was developed. The Letter of Agreement stated:

1. Effective July 17, 2006[19], two (2) of the existing Nurse Manager positions will be re-classified as RN Supervisor, to be included with the ONA bargaining unit. The job description for the Nurse Manager and RN Supervisor will be merged, where applicable, to create a single job description of RN Supervisor. The third (3rd) Nurse Manager position will be reclassified as a Clinical Standards Coordinator, excluded from the bargaining unit.
2. The resulting additions to the bargaining unit will provide for three (3) RN Supervisors working 12 hour extended tours, seven (7) days per week, subject to Management's right to lay-off in the future.
3. All Full-time RN Supervisors will rotate on days and nights on the adjusted nursing schedule except for the one RN who is permanently accommodated with a Dayshift rotation.
4. The Employer and the Union will review the impact of these changes on the RN workload no later than November 30, 2006, in conjunction with ONA.

At the same time as the above changes were implemented, an RPN Team Leader role was introduced on each of the four units (Apple, Maple, Birch and Willow) to support consistency and continuity on the units in the absence of a unit-dedicated Nurse Manager.

From the RNs' perspective, there was an improvement in workload following the implementation of their 12-hour shift schedule and the RPN unit-based Team Leader coverage. Only 10 PRWRFs were filed between September 2006 and June 2007, and on June 14, 2007, Mariana Markovic (Professional Practice Specialist, ONA) wrote to Beth Campbell (Cassellholme Administrator) indicating that workload concerns at Cassellholme (as presented to date) were considered resolved.

From Cassellholme's perspective, implementation of the 12-hour RN shifts and the RPN Team Leader roles led to increased resident and family complaints, and decreased continuity on the resident units. At the June 14, 2007 Union-Management Meeting, Cassellholme indicated that it was considering discontinuing the RPN Team Leader positions[20]. In August 2007, the Director of Clinical Services contacted the Bargaining Unit President to inform her that the current 12-hour RN rotation would be changing to a combined 8-hour / 12-hour rotation, with four (4) RN Supervisors working 8-hour shifts on a dedicated unit, and four (4) RN Supervisors working 12-hour shifts on a float basis, in order to support continuity in light of the discontinuation of the RPN Team Leader role[21].

The Association expressed concern with the new schedule at the September 11, 2007 Union-Management Meeting, believing it contravened the June 2006 Letter of Agreement, and filed a grievance on September 13, 2007. In addition to the schedule, responsibility for completion of performance appraisals was briefly discussed. The Minutes[22] of the September 11, 2007 meeting

[18] Email from Mariana Markovic to Shani Giroux, May 17, 2006.
[19] Actual implementation date was September 11, 2006.
[20] The IAC understands that discontinuation of the RPN Team Leader positions occurred as a result of a mediated agreement between Cassellholme and CUPE, which was developed in response to CUPE's concerns that in the RPN Team Leader role, RPNs were supervising other staff (PSWs) within the same bargaining unit.
[21] The combined 8hr/12hr rotation included the addition of one full-time RN Supervisor position.
[22] The Minutes received by the IAC were not signed, and it is not clear whether they were drafted by Cassellholme or the Association.

state: "There was some general discussion about current practice and cell phone interruptions, performance appraisals, having a scheduler after hours and a general statement that some RPNs are not working up to their scope of practice. There were no formal recommendations or decisions made from these general discussions".

Following extensive discussion at the November 21, 2007 Union-Management Meeting, Cassellholme and the Association signed a Letter of Agreement on January 28, 2008, which stated that the Parties agreed to the following:

1. A Master Schedule containing a combination of 7.5 hour tours and 11.25 hour tours has been designed and discussed with the nurses. Each full-time nurse has selected a line on the schedule.
2. This schedule will start on January 28, 2008. A trial of this new master schedule will run for a nine (9) month period and a further vote of the bargaining unit nurses at the Home will be conducted. The Parties agree to meet after four (4) months into the trial period to review any feedback from the nurses to make recommendations to improve the schedules, if needed.
3. A further vote will be conducted by September 26, 2008. Where at least seventy-five (75%) percent of the bargaining unit nurses indicate their willingness to continue with this master schedule, the arrangement will continue. If not accepted, the parties revert to their respective rights under the collective agreement.
4. This arrangement does not preclude the Home from introducing revisions or alternative scheduling arrangements to address Resident Care needs. Any changes necessary will be discussed with ONA.

Concurrent with implementation of the new combined 8-hour / 12-hour rotation, the full-time RN Supervisors were each assigned responsibility for completing performance appraisals for 18-20 staff[23]. As well, in an effort to address the unmet standards identified in the June 2008 MOHLTC Compliance Annual Facility Review, Cassellholme implemented a series of audits to monitor staff performance and resident care in the summer of 2008. These were primarily completed by the RN Supervisors, and added to their role responsibilities.

In accordance with the January 2008 Letter of Agreement, the RNs voted on the combined 8-hour / 12-hour schedule in September 2008. 72% of the RNs voted to return to the 12-hour rotation, and only 28%, rather than the 75% stipulated in the Letter of Agreement, voted to continue with the combined schedule. Cassellholme felt that the Unit-based assignment[24] of the four RN Supervisors working an 8-hour shift Monday to Friday was necessary for consistency and continuity of resident care, and did not agree to return to the original 12-hour rotation. The Association filed a grievance on October 18, 2008; the arbitration settlement reached on November 17, 2008 continued the combined schedule for two 16-week rotations (January 12 – August 23, 2009) and stated:

> ….. On or before August 23, 2009, the parties shall meet in Labour Management Committee to assess whether the combined rotations should be continued. If the parties don't agree to continue the combined rotations, they shall revert to their current positions and continue the arbitration and revert to their respective rights …..

In February 2009, Cassellholme commissioned an Operational Review of the Nursing Department by Tulia Ferreira of Responsive Health Mentors. As stated in Responsive Health

[23] The IAC understood that during the period September 2006 – January 2008, when the RN Supervisors worked a 12-hour rotation and there were no Nurse Managers, the performance appraisals of all staff were completed by nursing management. However, Cassellholme acknowledged that the completion rate during this period was low.

[24] Each 8-hr RN Supervisor is permanent assigned to a unit – Apple Maple, Birch and Willow.

Mentor's proposal, the purpose of the review was to provide recommendations regarding clinical programs, nursing processes and system, documentation tools, risk and quality management, resident safety programs, compliance with legislative requirements, leadership effectiveness at the unit level, and the role of the RN Supervisor and RPN. A number of the Cassellholme staff were interviewed by the consultant. The Report, which was received by Cassellholme in April 2009, has not been shared[25].

Union-Management Meetings were held sporadically throughout 2008 and 2009, with two occurring in 2009, on April 22 and June 2, 2009. However, the structure of the meetings appeared to be much more fluid than in previous years, with meetings cancelled at short notice (by both parties) and inconsistent minutes documentation (with consequent apparent lack of follow-up of identified issues).

Responsibility for completion of performance appraisals by the RN Supervisors was discussed at the April 22, 2009 Union-Management Meeting, following which the Association filed a grievance on May 21, 2009 regarding this issue. The arbitration settlement of September 11, 2009 continued RN Supervisor responsibility for completion of performance appraisals for RPNs and PSWs, and required Cassellholme to modify the appraisal form and to provide education sessions regarding the performance appraisal process to the RNs by December 2009. Although the form was revised and was discussed at the September 2009 Monthly RN Meeting, it was not distributed to all full-time RN Supervisors until February 2010 and education sessions were not provided[26].

The evaluation of the combined 8-hour / 12-hour schedule, referenced in the January 2008 Letter of Agreement, did not occur in August 2009 as required, and this issue has also been referred back to arbitration[27].

On July 23, 2009, Mariana Markovic wrote to Brenda Loubert notifying Cassellholme of the Association's decision to proceed to an Independent Assessment Committee. The Association referred the Professional Responsibility Complaint to the IAC Chairperson on October 6, 2009. Notwithstanding this, the Association and Cassellholme attempted to find dates to discuss the PRC outside of a Hearing, but were unable to find mutually agreeable dates in December or January. The Hearing thus proceeded on February 9 – 11, 2010.

[25] The Association requested disclosure of the Ferreira Report while preparing its Hearing Brief. The IAC Chairperson discussed this request for disclosure with Lise Ellis (Human Resources Manager, Cassellholme) by email, who responded on January 4, 2010 "As for the Operational Review prepared by Tulia Ferreira, this is not for public viewing. This is a very high level internal document that is not at completion and will not be disclosed to any party". The IAC has not received a copy of the Report.

[26] On January 18, 2010, the Association requested the arbitrator to resume arbitration. A tentative date has been set for April 2010.

[27] On January 18, 2010, the Association requested the arbitrator to resume arbitration. A tentative date has been set for April 2010.

2.3 Hearing Presentations

The Hearing was held February 9 to 11, 2010. The Hearing was structured such that on February 9, 2010, each of the Association and Cassellholme made an oral Submission presentation, maximum 90 minutes in length, highlighting the key elements of their previously submitted written Brief. On February 10, 2020, Cassellholme and the Association each made an oral Response Presentation which concluded with an opportunity for the other party to clarify / discuss / challenge / question information presented.

2.3.1 Ontario Nurses' Association Submission Presentation

The Association Submission Presentation, presented by Jo Anne Shannon and Christine Byrnes, was based on the Association's written Submission Brief and 73 exhibits of supporting/explanatory material.

The Association opened its Presentation by referencing a College of Nurses of Ontario (CNO) "Employer Information Session" held in Toronto in June 2004 for nursing leaders in long term care facilities. The session highlighted that the nursing practice concerns most often reported to CNO were

- failure to assess the client,
- failure to intervene / take appropriate action,
- medication administration / documentation,
- failure to ensure client safety, and
- poor interpersonal / communication skills

The Association referenced the CNO *Professional Standards*, which indicated that RNs are accountable to provide, facilitate, advocate and promote best possible care for clients, and to take action in situations where client safety has been compromised. The Association stated that the RNs at Cassellholme have met these Standards by documenting and reporting their concerns through the Professional Responsibility Complaint process.

RNs at Cassellholme have been completing PRWRFs since 2005. The Association highlighted the key issues identified through the PRWRF submissions from 2005/06 through to 2010, and indicated that many of the issues identified in 2005/06[28] are still current.

In reviewing events that have occurred at Cassellholme relating to professional responsibility since 2005, the Association noted the following:

- The Letter of Agreement developed between Cassellholme and the Association in June 2006 was an outcome of the Cassellholme Management Restructuring Report. The Association understood that the clinical responsibilities of the former Nurse Manager positions, comprising 80% of their role, were to be included within the newly created RN Supervisor positions, and that the administrative responsibilities of the former Nurse Manager positions, comprising 20% of the role, were to be assumed by management (and not within the revised RN Supervisor role responsibilities).

[28]Working short staffed due to the inability to replace absences; added responsibilities left uncompleted from previous shifts (assessments, medications, treatments etc.); communication issues; manager-on-call availability; inadequate orientation time and resources; outdated policies and procedures.

- Following implementation of the June 2006 Letter of Agreement, the RN Supervisors began working a 12-hour shift rotation in September 2006. The RNs found that the 12-hour shift provided improved coverage on nights and weekends, with a consequent improvement in workload. This improvement continued until the discontinuation of the RPN Team Leader role in October 2007.

- Following implementation of the mixed 8hr/12hr RN schedule in January 2008, when difficulties covering night and weekend shifts increased, RNs were formally assigned responsibility for completion of probationary and annual performance appraisals of RPNs and PSWs.

- The additional implementation of a series of audits, following the MOHLTC annual Compliance Review in July 2008, further exacerbated the RN Supervisors' workload. During 2008-09, a total of 143 PRWRFs were submitted[29], with a number of issues consistently identified:
    - shortage of RN staffing resulting in the need to cover more than one unit;
    - shortage of RPN staffing, resulting in RNs assuming duties, tasks and responsibilities of RPNs;
    - inability to complete assigned audits and performance appraisals;
    - late or inadequate documentation, delayed medication administration, physician order processing and treatments;
    - inability to assess status/intervene in the care of complex or high acuity residents, and effectively supervise RPNs and PSWs;
    - lack of equipment or supplies;
    - high volume of issues/assignments/responsibilities not resolved on Monday-Friday day shifts, resulting in increased workload on evening/night/weekend shifts; and
    - high volume of time spent calling in staff due to sick calls/other absences.
- The Association stated that these issues were directly related to the most frequently reported nursing practice concerns reported to the CNO, as referenced at the opening of the presentation.

The Association identified a number of factors that it believes are also impacting the RN Supervisor workload. These include:

- increase in resident acuity between 2004 and 2008, as demonstrated by the increased CMM and CMI, as well as anecdotal comments of the RNs;
- recruitment and retention issues, with an attrition level above and length of employee service level below other Homes for the Aged, represented by the Association, north of Barrie; and
- lack of an effective Union-Management meeting process, as the last Union-Management Meeting was held in April 2009[30].

The Association then reviewed the 29 recommendations included in their Brief (Appendix 7), and additionally noted that:

- An effective recruitment/retention program involves more than 'just' advertising for vacancies; issues in the work environment need to be addressed and improved so that current employees will want to stay and future nurses will want to come;

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[29] 84 PRWRFs in 2008; 59 PRWRFs in 2009

[30] The meeting held in June 2009 did not have an agenda or minutes.

- The Association's proposed staffing pattern would address the issues identified by the RNs in their September 2008 vote to return to a 12-hour shift[31], and would provide .022 RN hours / resident / day (current ratio at Cassellholme is .20). A ratio of 0.22 is less than the facility average of 0.3 RN hours / resident / day reported in 2001 by Price Waterhouse Coopers, and less than the 0.59 hrs recommended in the 2005 Casa Verde Coroner's Report.
- Implementation of the RAI flow sheets is currently in process but it is not yet clear who will be responsible for auditing these; the Association believes the RAI Coordinators should be responsible, but fears that this responsibility will be downloaded to the RN Supervisors.
- Redistribution of the Schedulers' hours of work by discontinuing the current four-hour overlap between 1400 – 1800 Monday – Friday would enable cost-neutral expansion of the hours of coverage from the current 0600 – 1800 to 0600 – 2200.
- Increasing the medication and supply restocking from once per week (on Thursday) to twice per week (Monday and Friday) would decrease the likelihood of supplies and equipment being unavailable.
- Although the number of RNs is fairly small, communication difficulties ensue as minutes of the monthly RN meetings are not widely distributed in a timely fashion, and discussion at the Thursday morning meeting between the Director of Clinical Services and the RN Supervisors working that day is not recorded.
- Effective implementation of RNAO Best Practice Guidelines requires more than having the binders available.

The Association highlighted a number of quotations from research papers and reports supporting both the concerns identified by the RN Supervisors and the recommendations proposed.

The Association stated that after almost five years of attempting to address Professional Responsibility workload issues, many outstanding issues remain. The Association believes that despite the large number of PRWRFs submitted since 2005, there were likely many more shifts where these forms could have and should have been completed.

The Association concluded its presentation with a statement by Christine Byrnes entitled "I Asked Myself "What Resident is at Risk – Name One! *The resident who is at risk is likening to the Unknown Soldier….the victim yet undisclosed…..*" (Appendix 8).

2.3.2 Cassellholme Submission Presentation

Cassellholme's presentation, presented by Ward Jones, was based on Cassellholme's written Submission Brief and 25 Exhibits of supporting/explanatory material.

Cassellholme opened its remarks by referring to three specific issues:

- The IAC Chairperson's introductory statement that the goal of the IAC Professional Responsibility Complaint Hearing is to achieve a positive resolution; Cassellholme stated that the Employer has the same goal, but feels that the Association is coming to the process with an opposite perspective. Specifically, Cassellholme believes that the

[31] These reasons included: provision of a four-hour 'buffer' between 1500 – 1900 to complete responsibilities not finished by 1500, provide better coverage of RNs on evenings, nights and weekends, including consistent filling of the 1000 – 2200 12-hour shift on weekends, better schedule and less nights for the existing 12 hour RNs and more time off for the existing 8 hr RNs resulting in improved work-home life balance.

February 2, 2010 front-page article in the *North Bay Nugget* entitled "Nurses Question Cassellholme Care" ambushed the process and was an unnecessary and unfortunate turn of events, especially considering that the IAC recommendations are non-binding and that there are strict limitations regarding the IAC's scope. Cassellholme stated it hopes that between the Hearing and receipt of the IAC's Report, similar tactics do not occur.

- The IAC Chairperson received Cassellholme's Brief after the due date because of the discovery that residents' names had been inadvertently left on a number of the exhibits, necessitating recopying of material with the names removed. Cassellholme noted that the Association's Brief included these same exhibits, including the residents' names.
- The MOHLTC announced on February 5, 2010 that Cassellholme has been approved for redevelopment in Phase I of the MOHLTC Renewal Strategy. It is anticipated that this redevelopment will result in significant infrastructure enhancements, for which construction will begin in 2011.

Cassellholme is a 240-bed accredited Home for the Aged, governed by a Board of Management. Originally beginning as a 50-bed 'house of refuge of care for the poor and elderly' 85 years ago, the Cassellholme health care campus has evolved to now include Castle Arms, a 224 unit not-for-profit apartment for seniors and Community Support Services (CSS)[32]. Cassellholme has approximately 300 employees, of which 12 positions are within the ONA Bargaining Unit. These positions are currently structured as 8 full-time and 4 part-time; 2 of the part-time positions are currently vacant.

Cassellholme reviewed the chronology of the Professional Responsibility Complaint, and indicated the following:

- The decision to move the previously non-unionized Nurse Managers into the bargaining unit in 2006 acknowledged the professional supervisory capabilities of the RN classification as leaders in the facility and facilitated their seamless integration into the direct care of residents.
- The 60 PRWRFs received in 2009 break down to an average of about only one per week. Cassellholme believes that it is common within the long-term care environment that duties are not completed at the end of a shift, and that this is the present nature of the health care system.
- Cassellholme would expect events such as suspicious deaths, injured RNs, discipline of RNs, or safety complaints to have occurred if the RN workload was too heavy. In fact, none of these have occurred, and there have been a number of initiatives (such as technology, scheduling, cell phones) that have been implemented to ease the RN Supervisor workload.

Cassellholme feels that the relationship between itself and the Association is "at best cordial", and provided the following examples:

- The vast majority of employees at Cassellholme are represented by CUPE, but over the past five years, there have been far fewer grievances and arbitrations than with members of the ONA bargaining unit.
- The Union-Management meetings have not been productive, and Cassellholme has perceived the atmosphere as hostile. The constant solution offered by the Association is 'more staffing'.

[32] CSS includes the Adult Day Hospital, Meals-on-Wheels, Diners Club/Congregate Dining, Supportive Housing, Home Help/Homemaking, Home Maintenance and Repair and Caregiver Support/Respite. Cassellholme staff, including the RN Supervisors, are not involved in or responsible for any of the CSS programs.

- A Professional Practice Specialist from the Association sent a letter in November 2009 directly to the Chair of the Board of Cassellholme advising the Board of the impending IAC process. Cassellholme viewed this letter as counterproductive, and felt that at a minimum, the letter should have been copied to the Administrator as a professional courtesy.

With respect to recruitment and retention, Cassellholme acknowledged that it is experiencing a shortage of RNs and RPNs, but feels this must be considered within the context of the fact that there is a national nursing shortage, which is outside of Cassellholme's direct control. In addition, Cassellholme has successfully recruited a number of nurses who did not remain because they were unable to meet employer standards. Cassellholme expressed frustration that 95% of the PRWRFs submitted in 2009 referred to 'staffing' or 'staffing shortages' as a factor, despite the fact that the RNs are aware that every effort is being made to fill vacancies.

Cassellholme stated that Section 10.01 of the Collective Agreement outlines four core factors which mandates the IAC's responsibility: "the employer has assigned……" … "too many residents….." .. "too heavy a workload….." .. "improper resident care…..".

With respect to the first factor, *"the employer has assigned"*, Cassellholme stated that it is responsible as the employer to have the required tools in place for RNs to work, but that RNs are responsible to use their skills to do the work. The compliance issues identified by the MOHLTC have been largely rectified. Cassellholme believes that the auditing process, the focused education specific to the standards and the expectation that RNs provide supervision have been instrumental in this improvement. Cassellholme also emphasized that not being in compliance does not automatically mean that the employer has assigned too heavy a workload to RNs, and that it makes every effort to replace absent staff, even at overtime rates.

With respect to the second factor *"too many residents",* Cassellholme stated that the number of regulated nursing staffing (RN and RPN) hours has doubled between 2000 and 2009[33] [34] despite the fact that the number of residents has remained consistent at 240, and that Cassellholme compares favourably with long-term-care facilities in Northern Ontario regarding staffing hours.

Regarding the third factor, *"too heavy a workload*", Cassellholme stated that the 60 PRWRFs submitted in 2009 need to be considered within the context of the residents' care requirements and the RNs' role responsibilities to supervise staff to ensure the highest quality of care is delivered to residents, to evaluate employee performance and to delegate work to RPNs and PSWs.

Cassellholme attributes the increase in CMM and CMI experienced since 2007 to improved documentation of care needs rather than an increase in actual care level requirements, and believes that the acuity of residents has not, in fact, increased substantially.

Cassellholme stated that audit requirements, such as those at Cassellholme, are common in other industries (such as accounting). Cassellholme stated that while the RNs may view the audits as additional work, they in fact serve as a check to ensure standards are being met and to enhance

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[33] Monday to Friday: 2000 – 48 hours; 2009 – 96 hours – 100% increase
Saturday – Sunday: 2000 – 40 hours; 2009 – 80 hours - 100% increase

[34] During discussion at the Hearing, these figures were subsequently revised to include the RPN med nurses:
Monday to Friday: 2000 – 176 hours; 2009 – 224 hours – 27% increase
Saturday – Sunday: 2000 – 168 hours; 2009 – 208 hours – 24% increase

employee accountability, and are standard supervisory responsibilities within the long-term-care practice environment. Cassellholme indicated that the audit requirements are not a heavy burden for the RNs and do not require a significant amount of time (Cassellholme estimates audit completion takes 2% of total shift time).

Cassellholme stated that the RN Supervisors' responsibility for completion of performance appraisals is not new. Each full-time RN Supervisor is expected to complete 18-20 performance appraisals per year. The completion rate over the past year was 42%. Cassellholme believes performance appraisal completion does not require an onerous time commitment, only 1-2% of time over the course of a year, and that with the flexibility to plan performance appraisals, completion is less a matter of workload than of accountability. Cassellholme feels strongly that the Association has acknowledged that the requirement to complete performance appraisals is not contradictory to CNO standards[35], and that the only issue outstanding is amendment of the performance appraisal tool and provision of education to the RN Supervisors.

The fourth factor, *"improper resident care"* is measured in terms of meeting MOHLTC Standards. The MOHLTC Compliance Audit for 2008/09 indicated that Cassellholme met most standards, and that for those standards not met, the problem was a lack of supervision rather than workload. Cassellholme noted that at the 2008 and 2009 Annual Reviews, the Compliance Advisor indicated that basic unmet resident care needs were very obvious and should have been observed by the RN Supervisors. Cassellholme stated that if there had been immediate intervention by the RN Supervisor, many of the citings by the Compliance Advisors could have been avoided.

Cassellholme then reviewed the nature of the professional responsibility complaints, focusing on the 59 PRWRFs submitted in 2009. Cassellholme noted the following:

- 70% of the PRWRFs were submitted by two RNs, both of whom work in a 12-hour float role;
- the PRWRFs were completed on all shifts and across all units, with no one unit disproportionally represented;
- the majority of PRWRFs were completed on nights and weekends; these shifts have the highest level of absenteeism and the greatest difficulty in replacing shifts;
- 95% of the PRWRFs reference 'working short'. Although Cassellholme tries to replace every shift, employees are unable or unwilling to work. Cassellholme stated that if there were less absenteeism, there would be less PRWRFs. Cassellholme also noted that 'working short' does not mean that the RN can't prioritize or delegate, or that the available staff cannot pool together to get the work done.

With respect to attendance, Cassellholme referenced the Attendance Management Program in place, and stated that the restrictive scheduling language in the ONA Collective Agreement[36] contributes to Cassellholme's ability to get employees to work. Cassellholme believes that the ability to change schedules with a couple of days notice is common in other collective agreements, and would be beneficial[37]. This flexibility exists within the CUPE Collective Agreement in place at Cassellholme,

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[35] September 11, 2009 arbitration award
[36] Section 14.03 (c) i) states "once the schedule is posted, there is no obligation for a part-time employee to accept any additional shifts that may be offered". Section 14.03 (a) vi) states "any violations of the master scheduling restrictions shall result in premium payment". Section 15.06 states "if the Employer changes the work schedule without at least a 24 hours advance notice of the scheduled reporting time, the employee will receive time and ½ her regular rate of pay for her next scheduled shift; such provision does not apply where the Employee mutually agrees"
[37] Cassellholme was unsuccessful in obtaining this change in the November 2009 HLDAA arbitration.

Cassellholme briefly reviewed the decision to replace the 12-hour RN rotation with the mixed 8hr-12hr rotation in 2007, and reinforced its perspective that reintroduction of the 8-hr shift has improved resident care through improved continuity for MD Rounds, care conferences, admissions/readmissions, appointments occurring during the day Monday to Friday.

Cassellholme reviewed other factors relating to professional responsibility/workload, including recruitment challenges, the addition of a number of new positions to assist the RN Supervisors to focus on their duties relating to resident care, the provision of a range of education/professional development opportunities over the past year which have been (generally) poorly attended, and the strong safety record at Cassellholme.

Cassellholme concluded its presentation with the following Final Observations:

1. Employer not assigning too many residents or too heavy a workload for RNs.
2. Employer has policies, procedures and guidance for RNs.
3. Employer has a nursing shortage just like all other health care providers in Canada.
4. There is an appropriate staffing complement at Cassellholme in Clinical Services.
5. Compliance issues have been addressed.
6. Parties need to improve relationships.
7. Discussion re RN ability to prioritize and delegate.
8. Absenteeism a major cause of complaints.
9. Collective agreement scheduling restrictions a major cause of complaints.
10. Employer expects RNs to perform their assigned duties.

2.3.3 Cassellholme Response Presentation

Cassellholme reviewed in detail its perspective regarding a number of issues identified in the Association's submission. Issues particularly emphasized were the following:

- The initial collective agreement negotiated between Cassellholme and the Association included professional responsibility language because this is very standard language in ONA agreements, not because there were concerns re professional practice at Cassellholme at that time.

- Section 6 of the PRWRF includes recommendations that the RN believes should be addressed in order to prevent similar occurrences. Cassellholme's analysis of the content of Section 6 for the 225 PRWRFs submitted since 2005 indicates that 75% of all recommendations revolve around the need to deal with the RN shortage and inability of the Employer to replace employees. Cassellholme believes that the core issue revolves around
  - the Canada-wide RN shortage which is outside of Cassellholme's control, and
  - the level of absenteeism and Cassellholme's inability, due to the collective agreement scheduling provisions and so again outside of their control, to replace employees.

- Cassellholme acknowledges that recruitment is a problem, but does not agree that retention is an issue of concern. 3/10 RNs have been with Cassellholme for more than 20 years; 7 recruited since 1999 have remained. Cassellholme did attempt to create a Recruitment and Retention Committee in October 2008, but did not proceed due to concerns expressed by the Association Bargaining Unit President.

- Cassellholme determines staffing levels based on MOHLTC reviews and funding. Other than registered (RN and RPN) positions, Cassellholme does not have difficulty filling positions and feels the Association's statement that there is 'inadequate organization-wide base staffing' is unfair. Similarly, Cassellholme feels that the statement that there are 'inefficient scheduling practices' is inappropriate, given the restrictions within the ONA collective agreement which preclude changing assigned shifts after the rotation is posted, and the fact that the number of support staff dedicated to scheduling has increased over the past five years.

- Cassellholme does not use agency staff for shift replacement, but rather relies 100% on part-time and full-time RNs. If staff members are not willing to take additional shifts, there is nothing that Cassellholme can do about it. With respect to CUPE shift replacement, in 2009 there were 746 instances where an RN Supervisor had to replace an absent CUPE staff member (RPN or PSW); this is an average of twice per 24 hours, which Cassellholme does not believe is onerous or a contributing factor to workload. With respect to overtime, the number of times than an RN worked more than 80 hours in a two-week period was 17, which on average is 1-2 times per year per RN.

- Cassellholme is not the only long-term-care facility in Ontario with audits. Cassellholme does not agree it is appropriate to conclude that completion of the required audits means the RN is based in the office 100% of the time. The goal of the audits is not to add unnecessary duties to the RN Supervisor, but to ensure that residents receive proper care. Cassellholme recognizes that some of the audits are more time-consuming than others, with the MAR audit requiring the greatest time; Cassellholme is endeavouring to implement an electronic MAR to address this. Cassellholme estimates that completion of the daily, weekly and monthly audits require approximately 30 minutes over a 24-hour period (which is split between the RN Supervisors working over the 24 hours).

- Cassellholme considers performance appraisals to be a feedback communication tool, and reinforced comments made during the Submission Brief presentation that the 18-20 appraisals to be completed by each full-time RN Supervisor per year comprises only 1-2% of the total RN Supervisor workload.

- Cassellholme stated that there is no evidence to support the Association's statement that 'increased RN workload and care delivery process issues (that) have resulted in incidences of delayed, improper and/or unsafe nursing care'. Cassellholme again reinforced that the major contributing factors to the increased CMI have been the commitment to documentation of care level needs of residents, integration of MOHLTC standards directly into job descriptions, and education programs for all staff to reinforce the relationship of the standards with their role. Further, Cassellholme believes that computerized documentation, a dedicated Infection Control Nurse, enhanced RPN responsibility, dedicated Unit Assistants and other measures support effective resident care.

- Cassellholme stated that while both parties acknowledge the need to improve their relationship, this has nothing to do with a lack of respect for RNs, who Cassellholme sees as leaders in the organization, the 'number one' group and level just below the management level.

- Cassellholme referenced the 2006 Letter of Agreement relating to amalgamation of the Nurse Manager and RN Supervisor roles/integration of the previous Nurse Managers into the

bargaining unit and implementation of the 12-hour shift rotation, stating that Cassellholme had thought the Letter of Agreement was a one-time implementation.

- With respect to the Association's statement that 'It is ONA's opinion that the employer considers any RN on her day off as 'available to work'', Cassellholme stated that the full-time and regular part-time RNs are the only resource to rely on when there is a need to replace an RN, that there is no available alternative and that Cassellholme considers there is nothing wrong with this approach.

Cassellholme concluded its Response Submission by quickly reviewing and commenting on the 29 recommendations submitted by the Association.

2.3.4 Ontario Nurses' Association Response Presentation

The Association opened its Response by apologizing for its error of including residents' names in Exhibit documents[38]. The Association then provided the following comments in response to Cassellholme's submission:

- Although the RN Supervisors are not directly responsible for the residents in or events at the Castle Arms apartments, they do receive calls for assistance and do have a key for Castle Arms in the locked cupboard in the Nursing Office for emergency situations.

- There are currently 8 full-time and 4 part-time RN positions; the 12-hour 2007 master rotation included 6 part-time positions, and the Association recommends that 6 part-time positions be re-initiated, to better improve relief staff availability and evening/weekend coverage.

- With respect to Cassellholme's statement that it is not uncommon for health care providers to have duties not completed, the Association expressed concern that Cassellholme appeared to be suggesting that RNs should not be completing PRWRFs when there are nursing practice issues. The Association stated that the CNO requires RNs to report nursing practice issues, and that once the employer is made aware of the concerns, nursing administrators are accountable to pursue solutions. The Association reviewed CNO accountabilities for administrative nurses[39].

- The Association agrees that the number of grievances at Cassellholme is disproportionate to the number of RNs and stated that there are more grievances at Cassellholme[40] than at any

[38] The documents with residents' names remained confidential among the IAC Committee members and those members of Cassellholme and the Association who received the submissions.

[39] Ensuring that mechanisms allow for staffing decisions that are in the best interests of clients and professional practice; ensuring the appropriate use, education and supervision of staff; advocating for a quality practice setting that supports nurses' ability to provide safe, effective and ethical care; creating an environment that encourages ongoing learning; advocating for a quality practice setting; knowing how to access resources to enable nurses to provide the best possible care; using relevant leadership and management principles; creating practice environment that support quality nursing practice; establishing and maintaining communication systems to support quality service and research; providing feedback and support to staff about nursing issues at an individual and organizational level; and involving nursing staff in decisions that affect their practice.

[40] 2008: 5 grievances, 3 resolved and 2 referred to arbitration, 1 resolved before and 1 mediated at Hearing
2009: 8 grievances, 5 resolved, 3 referred to arbitration, 2 resolved before and 1 mediated at Hearing
2009: Renewal Collective Agreement negotiations reached impasse and resulted in Hospital Labour Dispute Arbitration Act (HLDAA) Hearing

other Homes for Aged north of Barrie represented by the Association. The Association questioned why professional responsibility complaints are not effectively addressed at Union-Management meetings, and stated its belief that the Employer has full control over whether grievances can be resolved directly or whether resolution requires third party intervention.

- With respect to the wording in Section 10.01 of the Collective Agreement:
  - The Association does not narrowly interpret the words “the employer assigns a number of residents or a workload” to mean only ‘too many residents’, but to also include acuity requirements, resident care barriers, professional practice issues, resident safety or fluctuating staffing or workload. The Association noted that previous IAC Reports have recognized “workload” to include both direct and indirect factors.
  - The Association believes that the words “she or they have cause to believe” is the threshold RNs must meet when completing PRWRFs and that RNs are the best judges regarding whether they believe they have met the CNO standards or not.

- The Association believes that the change in schedule for RNs in January 2008 (from a straight 12 hour rotation to the combined 8 hour / 12 hour rotation), accompanied by the decrease in registered staffing hours (replacement of 4 RPN Team Leaders with 2 RPN floats), directly contributed to the increase in unmet standards identified in the MOHLTC 2008 Compliance Review. The Association does not agree with Cassellholme’s statement that compliance issues are not related to assigning too many residents or too heavy a workload to the RNs.

- The Association does not agree that policy/procedure binders are updated annually, and stated that in January 2010 Cassellholme indicated that the 2005 RN Supervisor job description, included in the Association Exhibits (#11), was being the most current version available. (Cassellholme included a 2008 version in their Exhibit).

- The Association believes that Cassellholme is failing to recognize the RN Supervisor’s role in assessing health care needs of complex or highly acute residents, delivering safe, ethical and competent nursing care, collaborating with RPNs and PSWs, communicating with MDs and residents’ families etc. The Association agrees that RNs practice in a leadership role, but believes that the CNO identifies a clear difference between assigning and supervising[41].
  - assigning is ‘allocating responsibility for providing care, may include any procedure’;
  - supervising is ‘monitoring and directing performance of specific activities for defined time period; may be direct or indirect, may include any procedure’.
- The Association disagrees with Cassellholme’s statement that delegating[42] work to RPNs and PSWs is a critical part of the RN role, stating that RPNs have the authority to perform controlled acts autonomously within their scope of practice and the Association does not believe that RNs or RPNs at Cassellholme delegate controlled acts to PSWs.

- The Association reiterated that RN Supervisors were not assigned responsibility for performance appraisals until 2008, and that prior to this, managers outside of the bargaining unit conducted all performance reviews.

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[41] College of Nurses of Ontario *Practice Guideline: Working with Unregulated Care Providers,* Publication # 41014, 2009, page 6

[42] The term ‘delegation’ has specific meaning under the *Regulated Health Professions Act*, and is defined by the College of Nurses of Ontario as “transferring the authority to perform a controlled act procedure to a person not authorized” (CNO *Practice Guideline: Working with Unregulated Care Providers,* Publication #41014, 2009*),* page 6

- The Association stated that audit and documentation requirements are 'locking the RNs in the office' and not enabling them to be out on units supervising care of residents, and that these requirements have increased the RNs' workload and increased the chance of negative residents outcomes. The Association does not agree that implementation of the audits has resulted in better resident care.

- With respect to the 42% completion of performance appraisals, the Association stated that the RNs feel that their workload did not permit time to complete the appraisals due to other assigned responsibilities and professionally working short, and that in instances of competing priorities, the RNs chose resident care priorities over performance appraisals. In addition, they were aware that the performance appraisal form was being modified and were waiting to receive the expected in-service training.

- The Association believes that both RN Supervisors and administrative nurses are accountable to CNO, and is concerned with Cassellholme's apparent reliance on the fact that the lack of suspicious resident deaths or facts surrounding resident incidents indicates a lack of resident risk. As noted in its Submission presentation, the Association believes it is the 'unknown resident' who is at risk.

- The Association challenged the statistics provided by Cassellholme regarding completion of the PRWRFs, numbers of education days taken by RNs, numbers of sick days[43], and numbers of PRCs/PRWRFs occurring in neighbouring long-term-care facilities, and disagreed with Cassellholme's statement that the majority of events (MD rounds, admissions, family visits, care conferences) are clustered on the day shift Monday-Friday.

The Association concluded its Response by highlighting a number of research articles that connect poor practice environments with a higher level of sick time. This literature was presented to refute Cassellholme's statement that it would be unfair to conclude that workload/work environment/work pressures are the cause of absenteeism.

[43] Cassellholme's sick time data was comprised of "sick time combined", which included 'paid sick days', 'unpaid sick days' and 'unpaid sick days not scheduled'; Cassellholme later clarified the statistics, which are referenced in Table 5.

SECTION III

DISCUSSION AND ANALYSIS

3.1 Introduction

The IAC believes that it has developed a comprehensive understanding of the professional responsibility concerns of the RNs working at Cassellholme. This understanding was achieved through review and analysis of the written submissions and exhibits, the oral presentations, and discussion at the Hearing.

In making its recommendations, the IAC considered three factors. The first is the scope of Gerontological Nursing as a unique specialty. As stated by the Gerontological Nursing Association of Ontario,

> *Gerontological nursing is a specialty that focuses on enhancing the quality of life for the older person in community and institutional settings. The goal of gerontological nursing is to promote optimal health in older persons. Gerontological nursing aims to maximize independence by identifying the strengths of the older person and working with him/her to enhance or maintain these strengths……Gerontological nurses provide creative, compassionate and individualized care incorporating the concepts of prevention, curative rehabilitation and palliation. This care acknowledges the older person's own abilities for health and health practices. Nurses in this specialty facilitate a healthful environment, and promote mutual goal setting and decision making among older persons, family and nurse.*[44]

The second factor relates to staffing standards in long-term care facilities. Following extensive analysis, the MOHLTC 2008 Report People Caring for People did not recommend that the *Long – Term Care Homes Act 2007* include a regulation providing a provincial staffing ratio or staffing standard. The Report stated:

> *Recent studies argue that staffing in LTC homes is a complex activity that requires consideration of a range of issues related not only to sufficient staffing capacity, but also to such factors as the mix of residents and their care needs, a home's philosophy of care, the service delivery model, the use of team approaches to care, and staff skill mix and experience. These studies strongly caution that simply establishing a staffing standard does not by itself address quality of life and care issues of LTC residents, and may in fact impede the consideration of other factors. If all available resources are used exclusively to increase staffing numbers, then the other areas related to improving the quality of the workplace, such as staff education and development, leadership development, team building and other areas would be affected.*[45]

The third factor relates to the role of the RN as a leader. One of the seven CNO *Professional Standards* is leadership:

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[44] Gerontological Nursing Association of Ontario: *Standards of Gerontological Nursing, 2004*

[45] *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*, MOHLTC, May 2008, pg 10
http://health.gov.on.ca/english/public/pub/ministry_reports/staff_care_standards/staff_care_standards.html

> *Each nurse demonstrates her/his leadership by providing, facilitating and promoting the best possible care/service to the public. Leadership requires self-knowledge (understanding one's beliefs and values and being aware of how one's behaviour affects others), respect, trust, integrity, shared vision, learning, participation, good communication techniques and the ability to be a change facilitator. The leadership expectation is not limited to nurses in formal leadership positions. All nurses, regardless of their position, have opportunities for leadership.*[46]

The CNO 2009 *Practice Guideline: Utilization of RNs and RPNs* further states:

> *In nursing, leadership includes the ability to facilitate client groups, develop plans of care, teach others, work in teams, lead teams, influence the work environment, and advocate for or bring about change. All nurses have the opportunity to develop leadership skills throughout their career.*[47]

As noted in Section 1.2, RN workload is influenced by client factors (e.g. complexity of bio-psycho-social care needs, cultural, emotional and health learning needs), nurse factors (e.g. nurse-resident ratio, roles and responsibilities of the RN and other care providers) and environmental factors (e.g. practice supports, consultation resources, physical environment of practice).

The IAC believes that the key factors influencing professional practice, and therefore impacting RN workload at Cassellholme, relate to

- roles and responsibilities, based on resident care needs and including
  - the resident care delivery model,
  - staffing of care providers,
  - the role of the RN Supervisor, including both administrative and clinical leadership; and
  - clinical resource nurse leadership

- leadership and quality care, including
  - the organizational structure of the Clinical Services Department,
  - recruitment and retention, and
  - monitoring of quality of care / audits;

- communication and culture; including
  - communication regarding professional responsibility concerns,
  - Union-Management Meetings, and
  - Clinical Services Intra-Departmental communication.

The IAC's comments and recommendations focus on these areas.

[46] College of Nurses of Ontario, *Practice Standard: Professional Standards, Revised 2002*, pg 10
[47] College of Nurses of Ontario, *Practice Guideline: Utilization of RNs and RPNs, 2009,* pg 7

3.2 Roles/Responsibilities and Staffing

The IAC believes that the workload of the RN Supervisor must be considered within the context of the model of resident care delivery, staffing of and roles and responsibilities of the members of the resident care team, and clinical resource leadership, all of which are based on the care needs of the residents.

3.2.1 Resident Care Needs

Cassellholme had a CMI of 96.41 in 2008[48], a 14% increase from 2002. There was substantial discussion at the Hearing regarding the reason for the change in CMI between 2002 and 2008. Cassellholme stated that the increase was due to improved documentation of resident care needs while the Association stated that the increase related to a true increase of resident care needs due to increased acuity, complexity etc. The IAC is less concerned with the historical reason for the change than with the fact that the current resident care needs at Cassellholme are relatively consistent with those at other Municipal Homes for the Aged across the province. In addition, the IAC noted that the current residents do not require a large number of high resource-intensity treatments, such as peritoneal dialysis or CPAP, and that Cassellholme brings in community-based nurses (through the CCAC) for care requirements that occur infrequently, such as IV administration.

The ‘level’ of care needs must be considered within the context of the configuration of the resident care units. The IAC understood that Cassellholme has managed, through placement of residents on the four Units, to maintain fairly consistent level of care requirements throughout the facility (other than the secure Unit, Cherry Lane). This, together with the fact that the four Units are fairly similar in size and design, suggests that a consistent model of care delivery can therefore be used on each of the four Units.

3.2.2 Resident Care Delivery Model

As noted in the People Caring for People Report, the quality of resident care and the quality of work-life are influenced by the care delivery model, not just the level of staffing[49].

Both Cassellholme and the Association discussed the need for, and importance of, continuity of resident care. Cassellholme believes that this continuity is ensured through assignment of one RN Supervisor to each of the four Units on a consistent basis (the RN Supervisor works days or evenings on her one Unit only), and strongly stated its position that continuity will not be as effectively provided if the RN Supervisors work 12-hour shifts. Cassellholme stated that during the period in 2006-07 when the RN Supervisors did work 12-hour shifts and unit coordination was managed by RPN Team Leaders, continuity and resident care suffered and resident/family complaints increased.

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[48] Provincial CMI data for 2009 are not available due to phased implementation of the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0)

[49] [49] *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*, MOHLTC, May 2008, pg 46

The Association believes that continuity of resident care would be enhanced on a 24-hour / 7 day per week basis if all eight (8) of the full-time RN Supervisors were consistently assigned to a specific resident care Unit, with two (2) RN Supervisors sharing responsibility for leadership on each of the three floors. The Association strongly supports the return to a 12-hour shift rotation, with each RN Supervisor dyad working opposite days on the master rotation (i.e. RN A and RN B work on Unit X: RN A works Monday/Tuesday, RN B works Wednesday/Thursday, RN A works Friday/Saturday/Sunday, RN B works Monday/Tuesday etc).

The IAC understands that the issue of RN Supervisor scheduling is returning to arbitration in April 2010, and is therefore hesitant to address this issue. Having said this, the IAC does not support continuation of the combined 8-hour / 12-hour shift rotation. The IAC believes that the competence and unique expertise of the RN within the long-term care environment will be maximized, and resident care and continuity enhanced, when all of the full-time RN Supervisors are permanently assigned to a specific Unit(s) and have a consistent accountability for resident care. The IAC believes that, in light of the small number of RN positions at Cassellholme, this consistency can be most effectively achieved with a 12-hour shift rotation. However, if a schedule can be developed using an 8-hour rotation with the same number of nurses, the IAC would support this. The key is that all full-time RN Supervisors have a similar leadership role and consistent accountability.

The IAC believes that implementation of a care delivery system using nine staff and resident specific 'pods' will promote better continuity of resident care, enhanced resident assessment, and improved communication between care providers. The IAC defines a 'pod' as designated RPN and PSW staff providing care to 18 – 36 specific residents who reside within a close geographical area, on an ongoing basis. The IAC envisages the nine pods to be:

- Apple Unit: Pod A1: 25 residents[50]
  Pod A2: 25 residents
- Maple Unit: Pod M1: 25 residents
  Pod M2: 22 residents
- Birch Unit: Pod CL1: 18 residents
  Pod B1: 26 residents
  Pod B2: 27 residents
- Willow Unit: Pod W1: 36 residents
  Pod W2: 36 residents

Cassellholme has already implemented a system whereby the RPNs and PSWs are consistently assigned to one specific Unit[51]. The IAC supports this decision, and believes that it should be taken further, to assign RPN and PSW staff to one of the nine pods, with one (1) RPN and two to four (2 – 4) PSWs working consistently with these residents and their families seven days per week[52], as indicated in Tables 7 and 8.

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[50] The IAC recognizes that the number of residents in each pod may vary slightly from the numbers identified (i.e. the two pods on Apple may be A1 24 residents and A2 26 residents), depending on the most efficient "split" based on the geographical configuration of the Unit.

[51] As of February 22, 2010, full-time RPNs work permanent shifts on their specific Unit.

[52] The RPN/PSW teams could alternate between the pods on each unit, each rotation (i..e. .those on Apple spend one full rotation on Pod A1, a second full rotation on Pod A2, and third full rotation on Pod A1 etc). This would foster continuity while still enabling the care delivery team to have a 'break' from some of the more challenging residents.

Table 7: Proposed Care Delivery Model: Weekdays

Unit	Days (0700 – 1500)		Evenings (1500 – 2300) 1500 - 1900		Evenings (1500 – 2300) 1900 - 2300		Nights (2300 – 0700)	
Apple: 50 residents	1 RN (D12)	Pod A1 25 res 1 RPN 3 PSW Pod A2 25 res 1 RPN 3 PSW	1 RN (D12)	Pod A1 25 res 1 RPN 2 PSW Pod A2 25 res 1 RPN 2 PSW	1 RN (N12)	Pod A1 25 res 1 RPN 2 PSW Pod A2 25 res 1 RPN 2 PSW	1 RN (N12)	Pod A1/A2 50 res 1 RPN 1 PSW
Maple: 47 residents		Pod M1 25 res 1 RPN 3 PSW Pod M2 22 res 1 RPN 3 PSW		Pod M1 25 res 1 RPN 2 PSW Pod M2 22 res 1 RPN 2 PSW		Pod M1 25 res 1 RPN 2 PSW Pod M2 25 res 1 RPN 1 PSW		Pod M1/M2 47 res 1 RPN 1 PSW
Cherry Ln 18 residents	1 RN (D12)	Pod CL1 18 res 1 RPN 2 PSW	1 RN (D12)	Pod CL1 18 res 1 RPN 2 PSW	1 RN (N12)	Pod CL1 18 res 1 RPN 2 PSW	1 RN (N12)	Pod CL1 18 res 1 PSW
Birch: 53 residents		Pod B1 26 res 1 RPN 3 PSW Pod B2 27 res 1 RPN 3 PSW		Pod B1 26 res 1 RPN 2 PSW Pod B2 27 res 1 RPN 2 PSW		Pod B1 26 res 1 RPN 2 PSW Pod B2 27 res 1 RPN 2 PSW		Pod B1/B2 53 res 1 RPN 1 PSW
Willow: 72 residents	1 RN (D12)	Pod W1 36 res 1 RPN 4 PSW Pod W2 36 res 1 RPN 4 PSW	1 RN (D12)	Pod W1 36 res 1 RPN 2.5 PSW Pod W2 36 res 1 RPN 2.5 PSW		Pod W1 36 res 1 RPN 2.5 PSW Pod W2 36 res 1 RPN 2.5 PSW		Pod W1/W2 72 res 1 RPN 1 PSW 36 res 1 PSW 36 res

Table 8: Proposed Care Delivery Model: Weekends

Unit	Days (0700 – 1500)		Evenings (1500 – 2300) 1500 - 1900		Evenings (1500 – 2300) 1900 - 2300		Nights (2300 – 0700)	
Apple: 50 residents	1 RN (D12)	Pod A1 25 res 1 RPN 3 PSW Pod A2 25 res 1 RPN 3 PSW	1 RN (D12)	Pod A1 25 res 1 RPN 2 PSW Pod A2 25 res 1 RPN 2 PSW		Pod A1 25 res 1 RPN 2 PSW Pod A2 25 res 1 RPN 2 PSW		Pods A1/A2 50 res 1 RPN 1 PSW
Maple: 47 residents		Pod M1 25 res 1 RPN 3 PSW Pod M2 22 res 1 RPN 3 PSW		Pod M1 25 res 1 RPN 2 PSW Pod M2 22 res 1 RPN 2 PSW	1 RN (N12)	Pod M1 25 res 1 RPN 2 PSW Pod M2 22 res 1 RPN 1 PSW	1 RN (N12)	Pods M1/M2 47 res 1 RPN 1 PSW
Cherry Ln 18 residents	1 RN (D12)	Pod CL1 18 res 1 RPN 2 PSW	1 RN (D12)	Pod CL1 18 res 1 RPN 2 PSW		Pod CL1 18 res 1 RPN 2 PSW		Pod CL1 18 res 1 PSW
Birch: 53 residents		Pod B1 26 res 1 RPN 3 PSW Pod B2 27 res 1 RPN 3 PSW		Pod B1 26 res 1 RPN 2 PSW Pod B2 27 res 1 RPN 2 PSW		Pod B1 26 res 1 RPN 2 PSW Pod B2 27 res 1 RPN 2 PSW		Pods B1/B2 53 res 1 RPN 1 PSW
Willow: 72 residents	1 RN	PodW1 36 res 1 RPN 4 PSW Pod W2 36 res 1 RPN 4 PSW	1 RN	Pod W1 36 res 1 RPN 2.5 PSW Pod W2 36 res 1 RPN 2.5 PSW		Pod W1 36 res 1 RPN 2.5 PSW Pod W2 36 res 1 RPN 2.5 PSW		Pods W1/W2 72 res 1 RPN 1 PSW 36 res 1 PSW 36 res

In this care delivery model, the RN Supervisor would be responsible for coordination of unit operations, including both resident care and operational/administrative responsibilities on her/his designated pods. The RN Supervisor and RPN would jointly complete / update care plans and resident-related audits.

The RPN would be responsible for administration of medications and provision of treatments for the residents within her/his pod. Over the past several years Cassellholme has worked hard to support the RPNs' movement to full scope of practice, the positive impact of which was unanimously supported by the RN Supervisors at the Hearing. Therefore, the IAC believes that the RPNs are now better prepared than they were in 2006 to provide first-line leadership for the care of a small group of residents within the pod.

Each PSW would have a resident assignment, with functional roles such as the "daily bath" PSW position discontinued. This approach would enable the PSWs to be more easily aware of and communicate changes in resident condition and care needs to the RPN, and would enhance RN Supervisor, RPN and PSW accountability with respect to resident care.

Recommendations:

1. ***Implement a care delivery model whereby a designated group RPNs and PSWs are consistently accountable for the provision of care to residents within one of nine pods, with leadership provided by an RN Supervisor dyad.***

2. ***Discontinue the current functional approach to role responsibilities (i.e. 'daily bath PSW' or 'treatment RPN').***

3. ***Implement a consistent leadership role for all full-time RN Supervisors, with accountability and responsibility for clinical and operational leadership of designated pods shared between 2-person dyads:***
   - ***one dyad responsible for the four pods on Apple and Maple (total 97 residents)***
   - ***one dyad responsible for the three pods on Birch (total 71 residents)***
   - ***one dyad responsible for the two pods on Willow (total 72 residents)***

3.2.3 Staffing

The IAC's proposed care delivery model provides for consistent RPN and PSW staffing seven days per week. As resident care needs met by RPNs and PSWs do not vary across days of the week, the IAC believes that staffing resources on the weekends should be consistent with those during the week.

Cassellholme's current PSW staffing provides for consistent coverage throughout the week; PSW staffing requirements for the proposed care delivery model therefore remain unchanged.

In order to provide consistent staffing seven days per week, the proposed care delivery model includes nine additional RPN shifts per week (1 additional RPN evenings Monday – Friday, 1 additional RPN days Saturday / Sunday and 1 additional RPN evenings Saturday / Sunday). In addition to providing consistent resident care, the IAC believes that the enhanced RPN staffing will have a positive impact on the workload of the RN Supervisors.

The current versus proposed RPN staffing requirements are summarized in Table 9.

Table 9: Current versus Proposed RPN Staffing : Weekday and Weekend

Unit	Days 0700 – 1500				Evenings 1500 – 2300				Nights 2300 – 0700			
	Weekday		Weekend		Weekday		Weekend		Weekday		Weekend	
	C	P	C	P	C	P	C	P	C	P	C	P
Apple	2	2	2	2	1.5	2*	1.5	2*	1	1	1	1
Maple	2	2	2	2	1.5	2*	1.5	2*	1	1	1	1
Cherry Lane	1	1	1	1	1	1	1	1				
Birch	1.5	2	1	2*	1.5	2	1.5	2	1	1	1	1
Willow	2.5	2	2	2	2.5	2	2.5	2	1	1	1	1
Total	9	9	8	9	8	9	8	9	4	4	4	4
+ / -				+1x2 = 2		+1x5 = 5		+1x2 = 2				

C = current P = proposed

The IAC understood that a key concern of the RN Supervisors is the decrease in the numbers of staff at 1500 and at 1900, when afternoon and evening activity is at a peak. The Association proposed an RN Supervisor schedule which included an 8-hour day and 8-hour evening shift (in addition to three 12-hour Day and one 12-hour Night shifts) Monday to Friday[53], so that two RN Supervisors would be available throughout the evening. The IAC does not support continuation of any form of a combined 8-hour / 12-hour shift, as it believes that this will continue the current imbalance of responsibilities and quality of work-life within the RN Supervisor group.

As indicated in Tables 7 and 8, the IAC is thus proposing a 12-hour shift rotation, with 3 RN Supervisors on Days and 2 RN Supervisors on Nights Monday to Friday, and 2 RN Supervisors on Days and 1 RN Supervisor on Nights on the weekends. This schedule would provide for consistent 7-day per week coverage of the four Units / nine pods, would ensure enhanced RN Supervisor coverage during the evenings, and would enable more time to be allocated to audit completion on nights (see Section 3.3). The IAC believes that coverage of the two first floor Units, Apple and Maple, can be effectively provided by one RN Supervisor dyad, due to the expanded RPN role and 'pod' care delivery model.

In addition, this schedule would involve all 8 of the full-time RN Supervisors, but would not require the part-time RN Supervisors to be pre-booked to their full commitment on the master rotation. They would thus be more available for coverage of anticipated (e.g. vacation) and unanticipated (e.g. sick, bereavement leave etc) absences. The IAC believes that more consistent coverage of absences will improve the work environment, and that, based on the 2009 sick time data with the current combined 8-hour / 12-hour schedule, implementation of a 12-hour shift will decrease sick time.

The proposed RN Supervisor staffing requires an additional 36 hours per week. The additional 60 hours of RN staffing during the week is offset by a decrease in budgeted RN staffing of 24 hours on the weekend, as indicated in Tables 10 and 11.

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[53] The Association proposed that the weekend staffing remain 'status quo', that is, three 12-hour RN Day and 1 12-hour RN Night shift. As noted in Section 2.1.4.2, Table 3, the current staffing plan includes a 12-hour 1000-2200 hour shift, which is rarely filled.

Table 10: Current versus Proposed RN Supervisor Staffing: Weekdays

Unit	Days 0700 - 1500		Evenings 1500 – 2300				Nights 2300 - 0700	
			1500 - 1900		1900 - 2300			
	C	*P*	C	P	C	P	C	P
Apple	1	*1*		*1*				
Maple	1		1		1	*1*	1	*1*
Birch/Cherry Lane	1	*1*		*1*				
Willow	1	*1*	1	*1*		*1*		*1*
Total #RNs	4	*3*		*3*	1	*2*	1	*2*
Total # Hours	32	*24*	8	*12*	4	*8*	12	*24*
+ / -		*-8 x 5 = (40)*		*+4 x 5 = 20*		*+4 x 5 = 20*		*+12x5 = 60*

8-hour shift
12-hour shift – current
12-hour shift – proposed

Table 11: Current versus Proposed RN Supervisor Staffing: Weekends

Unit	Days 0700 -1900		Evenings 1000 - 2200		Nights 1900 - 0700	
	C	P	C	P	C	P
Apple	1	*1*				
Maple			1*		1	*1*
Birch/Cherry Lane	1	*1*				
Willow						
Total # RNs	2	*2*	1	*0*	1	*1*
Total # Hours	24	*24*	12	*0*	12	*12*
+ / -				*-12 x 2 = (24)*		

*1000 – 2200 hours shift is rarely filled but is included within the rotation and staffing budget.
12 hour shift- current
12-hour shift - proposed

The IAC emphasizes that it is not 'wedded to' a 12-hour rotation. An 8-hour rotation would also be fine as long as the following principles are met:

- All full-time RN Supervisors work a similar schedule, i.e. some do not work 8-hour shifts and some 12-hour shifts;
- All full-time RN Supervisors are permanently assigned to specific pods, for which they are accountable for the provision of resident care, quality of care, staff performance and smooth operational functioning;
- The part-time RN Supervisors are available for relief coverage, and are not fully booked to their commitment in the master rotation schedule.

Recommendation

4. ***Implement a consistent (i.e. not combined) schedule for the RN Supervisors whereby the RN Supervisors are accountable, in dyad pairs, for the provision of resident care, quality of care, staff performance and smooth operational functional functioning of a the pods within a designated Unit(s) (Apple/Maple, Cherry Lane/Birch or Willow).***

3.2.4 RN Supervisor Role

There appeared to the IAC to be two distinctly different RN Supervisor roles currently in operation at Cassellholme, but only one job description. The four full-time RN Supervisors working an 8-hour shift rotation have a fairly traditional 'Unit Manager' role. They are responsible for the coordination and 'management' of the residents and staff within their Unit and are the go-to person for the Management team. They appear to be de-facto in the previous Nurse Manager role. The four full-time and four part-time RN Supervisors working a 12-hour rotation have a 'jack of all trades' role. They do not have a designated home Unit, are not accountable for the provision of care and operations in a specific area, appear to be expected to respond to any and all situations within the facility but have the same accountability for administrative responsibilities as their 8-hour shift counterparts. Nurses in both groups recognize the imbalance and are dissatisfied with the status quo, as evidenced by their interest in and willingness to move to a consistent 12-hour rotation for all.

A large component of dissatisfaction among the RN Supervisors appears to be based on expectations associated with the "20% administration function" assigned to their role. Both Cassellholme and the Association frequently referenced the '80% clinical / 20% administration' delineation considered to exist within the Nurse Manager role at the time that it was amalgamated with the RN Supervisor position in 2006. The IAC did not receive any clear documentation regarding the role responsibilities included within 'clinical' and 'administration', and is not sure if the 20% was originally intended to include completion of performance appraisals. The IAC is also unclear as to how well these responsibilities, and the expectation for full amalgamation into the RN Supervisor role, were articulated in 2006.

The IAC understood that Cassellholme's perspective is that, at the time of amalgamation in 2006, the full 100% of the former Nurse Manager role responsibilities were included in the new RN Supervisor role, and that the Association's perspective is that the new RN Supervisor role was to include the 80% clinical functions and the 20% administrative functions were to have returned to the Management team. The Association stated that in the first year following amalgamation of the roles, when the RN Supervisors worked 12-hour shifts, their role was 100% clinical, and that it was only when the RPN Team Leader positions were discontinued and the RNs moved to the combined 8-hour – 12-hour shifts that the expectation for administrative functions was defined to include performance appraisals (and in 2008, audits.)

The IAC believes that the RN Supervisor role should appropriately include both clinical leadership and administrative functions. As articulated by the CNO and referenced in Section 3.1, leadership *'includes the ability to facilitate client groups, develop plans of care, teach others, work in teams, lead teams, influence the work environment and advocate for or bring about change'*[54] As the leader working with RPN/PSW/resident pods, the RN Supervisor will have the opportunity to support the RPNs in the continuing development/implementation of a full scope of

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[54] College of Nurses of Ontario *Practice Guideline: Utilization of RNs and RPNs,* June 2009 pg 7.

practice, monitor resident care provided by RPNs and PSWs in terms of quality practice, and coordinate/manage the operations of the Unit to support effective practice. In addition, the RN Supervisors will have a more defined opportunity to develop/enhance clinical expertise in specific areas, to become the in-house clinical resource in areas such as fall prevention, pain management etc.

3.2.4.1 RN Supervisor Role: Administrative Leadership - Performance Review

The IAC is aware that RN Supervisors' completion of performance appraisals has been referred to arbitration scheduled for April 2010, with respect to the issue of provision of education sessions. The IAC understands that the issue of whether RN Supervisors should be completing performance appraisals is not being arbitrated.

Cassellholme stated a number of times during the Hearing that there is a difference between 'performance appraisal' and 'discipline', and that the RN Supervisors, while responsible for the former, are not responsible for the latter. The IAC concurs with this perspective, and believes that this differentiation will be more effectively supported if the RN Supervisor's role relates to 'review' of performance, rather than 'appraisal' of performance. The current performance appraisal tool requires the RN Supervisor to rate the RPN/PSW on a four point Likert scale[55] and to provide comments and recommendations, to which the RPN/PSW agrees or disagrees. The tool is generic to all departments, and does not directly relate to health care/nursing practice or the provision of quality resident care. Although the form is eventually also signed by both HR and the Administrator[56], the performance appraisal interview is conducted by the RN Supervisor, who is perceived by the RPN /PSW to be accountable for the process.

The IAC agrees that performance reviews conducted by persons who have only indirect knowledge of an individual's practice are of lesser value, and therefore believes that it is appropriate for the RN Supervisor to be involved. However, the IAC believes that the RN Supervisor's role should be to discuss the RPN/PSW's self assessment[57] in conjunction with her own review of the RPN/PSW's practice; these two documents should then be forwarded to the Director of Clinical Services or delegate (see Section 3.3.1), who is responsible for signing (and being accountable for) the review. The IAC does not believe that the RN Supervisor should be accountable for the performance review, but rather, to be responsible for one step in the performance review process. The IAC believes that reference to attendance should be removed from the performance review tool, as this relates to discipline rather than review of clinical practice.

Recommendations:

5. ***Replace the term 'performance appraisal' with 'performance review'.***

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[55] The categories currently rated are: job knowledge, work quality, work rate, communications, interpersonal relations, health and safety, attendance, and training and development.

[56] The Director of Clinical Services signs the performance appraisals of staff within the Clinical Services Department.

[57] Self assessment of practice and learning needs is an expectation of RPNs. The IAC believes that implementation of a self-assessment component will increase both accountability for and insight into practice on the part of the RPNs and PSWs.

6. ***Revise the performance review form used for RPNs and PSWs to include completion of an assessment and identification of learning needs/goals by the RPN/PSW and a review by the RN Supervisor.***

7. ***Revise the performance review process to include two distinct steps:***
    a) ***RN Supervisor to discuss with RPN/PSW the similarities/differences between the RPN's/PSW's self-assessment and RN Supervisor's review, and identify strengths / areas requiring development and learning needs/goals;***
    b) ***Director of Client Services or delegate (see Section 3.3.1) to assess the above documentation, summarize required next steps, take action with the RPN/PSW as required, and sign to formalize the performance review.***

3.2.4.2 RN Supervisor Role: Clinical Leadership - Best Practices

Cassellholme has taken the initial step towards the implementation of best practices within the facility, in that it has obtained a number of the Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines. However, the IAC believes that effective implementation will require an advocate/sponsor, clinical resource leadership and a defined implementation plan.

The Association's recommendations included implementation of 24 Best Practice Guidelines. The IAC does not support such a broad-brush approach; Cassellholme does not have the financial or human resources for such a enormous initiative, and the IAC believes that effective implementation of selected Best Practice Guidelines, rather than ineffective implementation of a large number, will have a more positive impact on both resident care and care provider morale.

In 2008, the RNAO Long-Term Care Best Practices Initiative Team[58] identified, through a survey of long-term care homes throughout Ontario, five top priorities in long-term care facilities:

- client centred care
- continence and constipation: assessment and management
- falls prevention and management
- pain assessment and management, and
- pressure ulcer risk prevention, assessment and management.

To assist staff in long-term care facilities to effectively implement these five clinical practice guidelines, the Best Practices Initiative Team developed a comprehensive Best Practices Toolkit ("implementing and sustaining change in long-term care").

The IAC believes that these five areas should be the focus for initial clinical practice guideline implementation at Cassellholme over the next 12 – 18 months. The IAC recognizes that, on the surface, responsibility for implementation of Best Practice Guidelines will seem to add 'more work' to the RN Supervisor role, thus increasing, rather than decreasing, their workload. However, the IAC believes that focusing the RN Supervisor role on clinical practice leadership will provide a higher level of satisfaction for the RNs, and implementation of Best Practice Guidelines will facilitate improved quality of care for residents, which will eventually result in less need for crisis management on the part of the RNs.

[58] The Long-Term Care Best Practice Coordinator role was a three-year pilot initiative funded by the MOHLTC through the Nursing Secretariat. The goal of the "Long-term Care Best Practices Initiative' is to support long-term care homes to integrate evidence-based practices into their procedures and protocols. In 2008, the RNAO assumed the management of the initiative with funding from the MOHLTC.

Recommendation:

8. ***The full-time RN Supervisors work in pairs to implement the following Clinical Practice Guidelines, accessing the resources available through the Best Practices Toolkit:***
    - ***Continence and constipation: assessment and management***
    - ***Falls prevention and management***
    - ***Pain assessment and management, and***
    - ***Pressure ulcer risk prevention, assessment and management***

3.2.5 Clinical Resource Nurse

As noted in the discussion above regarding implementation of Best Practice Guidelines (BPGs), the IAC strongly recommends the implementation of the five[59] clinical BPGs identified as priorities by the Long Term Care Best Practice Initiative. The IAC recognizes, however, that effective implementation will be difficult if the RN Supervisors do not have access to leadership resources.

The IAC therefore believes that Cassellholme needs to consider the creation of a Clinical Resource Nurse (CRN) role. The IAC believes that Cassellholme does not currently have the resources to 'build' the capacity of the RN Supervisors to develop into the clinical leadership role described below. The IAC believes that a CRN role would enhance the quality of care for residents through capacity building in nursing professional practice, nursing quality and education. The CRN would provide leadership in evidence-based practice, including basic research skills, project evaluation and initiatives such as BPGs. In addition, the CRN would provide nursing leadership into quality improvement initiatives related to safe, ethical and competent nursing care for residents based on MOHLTC guidelines, including contributing to provision of the orientation program for newly hired RNs and RPNs. The IAC expects that benefits would include improved resident safety and improved resident/family satisfaction, and research and analysis of audit data[60] to improve compliance with MOHLTC standards and resident care.

Many long-term care facilities in Ontario employ Masters-prepared Clinical Nurse Specialists to provide leadership for nurses regarding gerontological nursing practice. However, the IAC believes that a CRN position, requiring a BScN completed or in progress, reporting to the Manager of Clinical Standards, and included within the bargaining unit, would address the need for clinical leadership. In consideration of fiscal restraints, the IAC recommends that the CRN position be implemented for a two-year term period, with further continuation of the role based on a joint evaluation by Cassellholme and the Association regarding the position's impact and effectiveness. Further strategies to reduce the cost of this position could include:

- sharing the CRN position with another long-term care facility in North Bay and/or its surrounding districts (Nipissing/Parry Sound);
- positioning the CRN position as a series of short-term (4 month) contracts for Masters or post-RN BScN students;
- accessing funding through the Centre for Rural and Northern Health Research (CRaNHR); or

[59] Proposed implementation of the fifth BPG, Client Centred Care, is discussed in Section 3.4.3
[60] Audit analysis would be in tandem with the administrative manager responsible for audits (see Section 3.3.1)

- building on the Phase I Renewal Strategy to move Cassellholme towards becoming a 'centre of excellence in long-term care' ; consider approaching the Cassellholme Board or the Municipality for assistance with funding the CRN position.

The IAC recognizes the short-term fiscal impact of creation of the CRN role, but believes that the long-term cost savings will more than compensate. The IAC strongly believes that when the RN Supervisor and RPN (and PSW) staff are working within a satisfying clinical practice environment, there will be significantly less illness/absence[61].

The IAC also believes that promotion of an organizational culture which supports professional practice and learning will have a positive impact on the sense of accomplishment of the regulated staff, which will in turn positively impact job satisfaction and retention, and will decrease the sense of 'always running, never catching up' that is contributing to the RN Supervisors' workload frustrations.

Draft qualifications and role responsibilities for a CRN position are included in Appendix 9.

Recommendation

9. ***Implement a Clinical Resource Nurse Role for a two-year term period, beginning September 1, 2010. Decision regarding continuation of the role be based on a joint evaluation, by Cassellholme and the Association, of the role's impact and effectiveness on***
    a) ***Resident quality of care***
    b) ***Resident resident/family satisfaction, and***
    c) ***RN/RPN retention.***

3.3 Leadership and Quality Care

3.3.1 Nursing Leadership Organizational Structure

As noted in Section 2.1.4.1, the organizational structure within the Clinical Services Department is very flat. On paper, all but two of the staff within the Department have a direct reporting relationship to the Director of Clinical Services. The IAC believes that this approach does not easily enable effective leadership: the Director's span of control is too broad for meaningful direct connection with and/or support of the staff, and the staffs' perception is that leadership/management is 'top-down' and not inclusive of their perspectives or concerns.

The two Manager positions (Manager of Clinical Services and Manager of Infection Control and Documentation) are staff roles, with project management accountability, and, on paper, no line accountability for the practice/performance of RNs, RPNs, PSWs or Unit Assistants. However, in practice, the Managers are involved with performance, support/discipline and quality of practice issues as required.

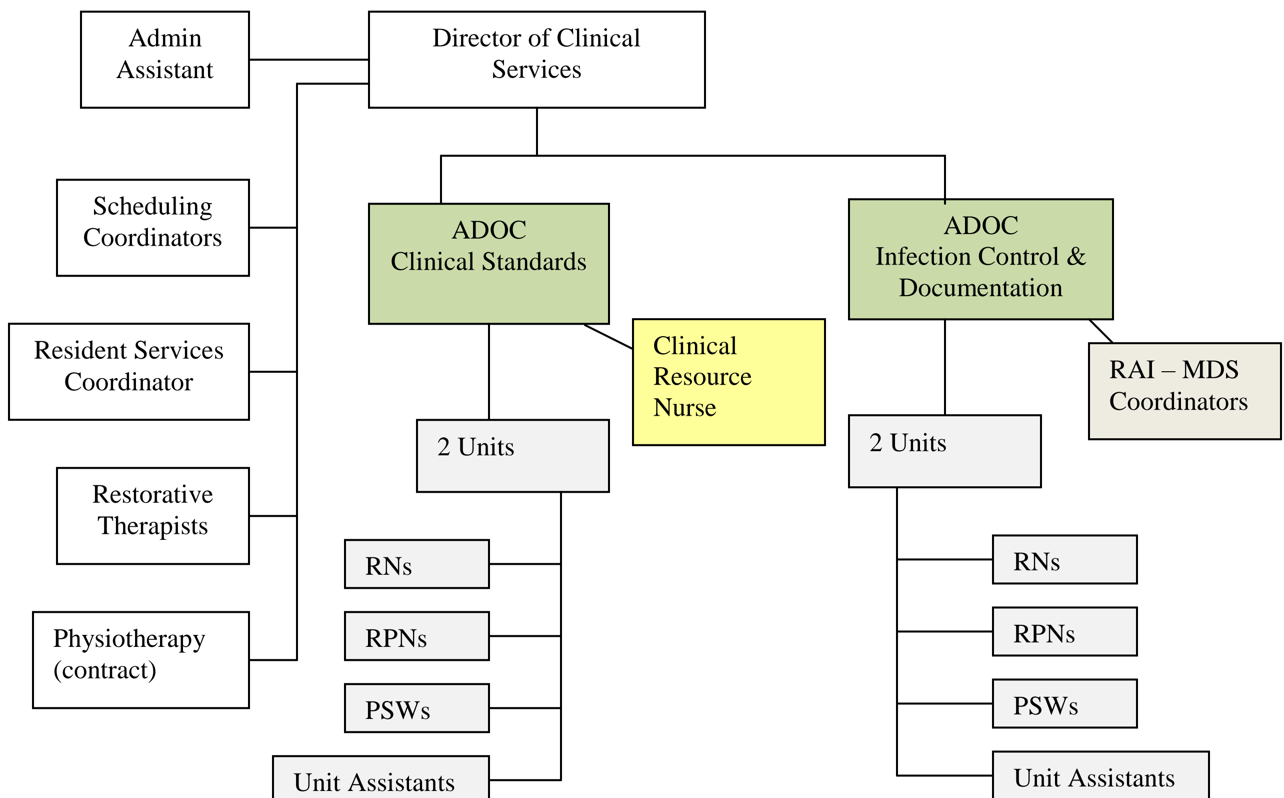
The IAC believes that the 'in practice' structure needs to be formalized, with accountabilities clearly defined. The IAC suggests that the Manager title be changed to Assistant Director of Care

[61] The IAC roughly calculated the costs of absences in 2009 to be between $55K and $100K. If these costs are decreased by 50%, the incremental cost of the CRN position will be minimal.

(ADOC) to indicate line as well as staff accountabilities. Each ADOC would maintain project responsibilities for Clinical Standards / Infection Control and Documentation. The Clinical Resource Nurse would report to the ADOC with responsibility for clinical standards, and the RAI-MDS Coordinators would continue to report to the ADOC with responsibility for Infection Control/Documentation. Each ADOC would assume line accountability for two of the resident Units, either 'Apple and Maple' or 'Birch/Cherry Lane and Willow'. Given the enhanced Unit-based leadership structure, with defined RN Supervisors and RPN/PSW pods, extensive day-to-day involvement of the ADOCs would not be required. The RN Supervisor would manage and deal with all clinical issues relating to resident care; the ADOC would be responsible for dealing with operational and quality of care issues that transcend the specific unit, as well as staff performance.

The IAC believes that this proposed structure, which is depicted in Diagram 2, will provide more support to everyone within the Clinical Services Department.

Diagram 2: Proposed Nursing Leadership Organizational Chart



Recommendation:

10. ***Revise the reporting relationships within the Clinical Services Department to provide a manageable span of control and articulate the line accountabilities of the three members of the Clinical Services Management Team. Specifically:***
    a) ***Manager title be changed to Assistant Director of Care (ADOC)***
    b) ***Each ADOC to maintain current project accountability, and assume line accountability for two Units (Apple/Maple or Birch/Willow)***
    c) ***RNs, RPNs, PSWs and Unit Assistants to report directly to the ADOC***

d) Director to retain direct reporting relationship Schedulers, Resident Services Coordinator, Restorative Therapists and Physiotherapy staff.

3.3.2 Nursing Leadership: Staffing, Recruitment and Retention

The People Caring for People Report included the recommendation that long-term care facilities utilize the RNAO healthy work environment best practice guideline *Developing and Sustaining Effective Staffing and Workload Practices.* The IAC believes that implementation of this best practice guideline, which includes a framework of a complex set of variables that impact on staffing decisions, suggested levels of decision-making (strategic, logistical and tactical, and addressing skill mix, status mix and contingency staffing) and a collaborative process for planning, would assist Cassellholme (management and nurses) to jointly build on the IAC's proposed staff mix/schedule to develop a staffing plan that optimally meets their needs.

The IAC is very aware of the recruitment challenges faced by long-term care facilities, particularly those in smaller northern communities. However, the IAC does not concur with Cassellholme's statement, made a number of times, that "there is nothing we can do". The IAC encourages Cassellholme to be creative and think more broadly about modes of recruitment.

The IAC believes that recruitment and retention need to be considered hand-in-hand. Recruitment quickly becomes a zero-sum game if retention issues are not addressed, and staff members leave an organization at the same rate as they enter it.

Recruitment and retention of RNs and RPNs is on the brink of becoming an even more significant issue with the impending opening of the new North Bay Regional Health Centre. Cassellholme (and all other North Bay nursing employers) will need to carefully address retention issues, as the likelihood of drawing nurses away from the new health centre will be low in the short to medium-term future.

An effective recruitment and retention strategy requires a three-prong focus: short term recruitment initiatives, long term recruitment planning, and retention strategies.

The IAC encourages Cassellholme to develop a more focused and formalized short term recruitment strategy, including initiatives such as:

- more effective marketing to 'get the word out' that nursing positions are available through, for example, working closely with local educators, involvement with campus/job fairs, participating in internet posting sites;
- dedicated focus on nursing recruitment during the four-month period January to April each year, when nursing graduates are actively seeking summer and long-term employment;
- using the Nursing Graduate Guarantee (through Health Force Ontario) to provide support for newly hired RNs (and RPNs), and marketing this initiative (to set Cassellholme positively apart from other local employers);
- working with municipal leadership to position Cassellholme within the local media as a leader within the East Nipissing District regarding community and facility-based long term care;
- continuing to promote the ONA contract as a recruitment tool;
- reviewing the operational hiring process to ensure that it is maximally effective in terms of support provided to applicants, timeliness of contact, scope and nature of the interview etc;
- ensuring that newly hired nurses experience a stable and supportive initial (first six

months) practice experience by participating in an effective orientation program[62].

The IAC believes that improving the quality of nursing work-life will have a significant impact on Cassellholme's ability to recruit and retain part-time nurses and decrease the stress and sense of overwhelming workload currently experienced by both the part-time and full-time RN Supervisors. The IAC also believes that implementation of a care delivery system which enhances a sense of 'team' and provides for a greater sense of 'making a difference' in the provision of resident care will assist in decreasing the current high levels of absenteeism among the RPN and PSW staff, which will, in turn, positively impact the workload of the RN Supervisors.

Recommendations:

11. ***The Clinical Services Management Team implement the RNAO healthy work environment best practice guideline Developing and Sustaining Effective Staffing and Workload Practices in 2010 and the best practice guideline Developing and Sustaining Nursing Leadership in 2011.***

12. ***Cassellholme develop a formal short-term recruitment strategy, which is evaluated q6 months in terms of numbers of staff recruited and ongoing vacancy rate, and includes:***
    a) ***expanded marketing, with use of campus/job fairs, internet posting sites (government, professional association, interest groups etc), municipal posting sites etc;***
    b) ***exploration of creative recruitment approaches, such as the Two Jobs in One strategy developed by OANHSS;***
    c) ***evaluation and revision as required of the hiring process, and the orientation program.***

13. ***Cassellholme develop a retention plan which addresses scheduling and quality of work-life issues, including:***
    a) ***Implementing a schedule which provides for***
        i) ***equal role responsibilities and opportunities for the full-time RN Supervisors;***
        ii) ***availability of part-time RN Supervisors to cover anticipated and unanticipated short and long term vacancies (i.e. the total 45-hour commitment not be pre-booked on the master rotation) thus decreasing the need to frequently request full and part-time RNs to accept extra shifts;***
        iii) ***consistent coverage of the shifts within the master rotation, to decrease the RNs' sense that they are 'working short' approximately 50% of the time; and***
        iv) ***opportunity for part-time RN Supervisors to indicate dates for which they are unavailable for personal reasons.***
    b) ***Discontinuing the unspoken message that staffing problems are the staff's (not management's) fault by***
        i) ***altering the staffing statistics categories by eliminating 'NAV', 'sick days combined', and 'unwilling to work on day off'; and***
        ii) ***revising Section 5.2 of the Attendance Management Program;***

[62] The IAC was concerned by Cassellholme's reports of the numbers of newly hired RNs and RPNs who did not successfully complete the probation period, and believes that this outcome relates to the quantity and quality of orientation support provided as well as the RN/RPN's competence.

c) ***Developing the RN Supervisor role responsibilities to enhance involvement in clinical and operational decision-making, provide opportunity for teaching, and articulate accountability for development of areas of clinical expertise (e.g. best practice guideline implementation), so that the RN role at Cassellholme mirrors the elements that new graduates are being taught. These elements of best practice are important within the practice and profession of nursing, and new graduates are looking for and expecting this practice in organizations today when they seek employment.***

3.3.3 Nursing Leadership: Quality of Care – Audits

The IAC is aware that audits are used extensively within the majority of long term care facilities in Ontario. As stated in the People Caring for People Report:

> *Stakeholders told us that LTC homes' efforts to be in compliance with MOHLTC requirements drive to a significant extent organizational priorities and decisions that affect staff capacity. Many stakeholders told us that this often results in situations where staff focus on compliance-related administrative and process activities instead of on providing care. In addition, they indicated that time dedicated to resident care is diverted to compliance related functions, many of which are related to documentation and other paperwork*[63].

The IAC commends Cassellholme's quick and focused response to address the nine areas of non-compliance with MOHLTC standards identified in the 2008 review. The fact that the 2009 review indicated only two outstanding non-compliance standards, and that Cassellholme has recently been informed that all unmet standards are now deemed to be in compliance[64] indicates that their efforts have been rewarded.

The IAC suggests that, now that Cassellholme has achieved a more 'even keel' with respect to MOHLTC compliance, a review of the audit requirements be conducted with respect to the number of and focus of the audits currently in place.

With respect to the number of audits, the IAC believes that Cassellholme could consider discontinuing the daily audits (resident care, resident room and dining room lunch), because with the pod care delivery model, daily resident assessment will be more effectively incorporated into nursing practice. The IAC agrees that the MAR and TAR audits should continue on a weekly basis, strongly supports Cassellholme's intention to move to an electronic MAR, and encourages the implementation of an electronic TAR as well (both of which are in existence in many long-term care homes in the province). The IAC does not entirely agree with either the Association's perspective that audit completion is largely an office activity, keeping the RN Supervisors off the floor and away from direct interaction with resident care, or with Cassellholme's contention that audit completion is not time-consuming. The IAC believes that a number of the audits do require work outside of the office, and that much more than 30 minutes over a 24 hour period is required.

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[63] *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*, MOHLTC, May 2008. pg 11

[64] Email from Ward Jones, Cassellholme Consultant to Joan Cardiff, March 11, 2010 stated "Re compliance, I have been advised that Cassellholme recently had their compliance review and there were no unmet standards and that any unmet standards have now been deemed to be in compliance".

One element of the IAC's recommendation to increase RN Supervisor staffing to two on Nights is to ensure more uninterrupted time for timely and comprehensive audit completion.

With respect to focus, the IAC believes that audits need to focus on the provision of resident care and that the outcome data needs to be analyzed to identify trends regarding unmet needs relating to resident care and practices/protocols requiring change, rather than weakness/performance of specific staff members. The IAC is concerned that at Cassellholme, the focus of the audits as evidenced by 'actions taken' appear to relate more to review of staff performance than to evaluation of resident risk and/or quality of care.

A number of audits require time-consuming review of staff schedules etc to identify by whom an omission was made. The 'actions taken' by the RN Supervisor relate to identifying the RPN/PSW name and shift and sending a 'counseling letter', which may lead to discipline by the Clinical Services Management team. The IAC believes that 'actions taken' need to relate to immediate action when a resident may be at risk (e.g. for falls, restraint) rather than omissions on the part of individual staff, that the RN Supervisor should not be responsible to approach the staff member unless resident safety is of immediate concern, and that any decision with respect to staff follow-up/discipline should rest with the ADOC[65]

The IAC encourages Cassellholme to use audit data to identify required changes in practice and/or trends in practice to support effective resident care. The IAC did not see or hear any clear examples where audit data has been used to inform practice, and believes that implementation of the CRN role will assist in this area.

The IAC has included a copy of two audit forms, currently used in a Home for the Aged in Ontario, as examples of how audit forms can be focused on resident care risk/outcomes rather than staff performance (Appendix 10).

Recommendations:

14. ***Implement an electronic MAR with associated electronic audit, by October 1, 2010, with the goal of the audit to identify the impact of missing medications on resident care. In the meantime, revise the Weekly MAR audit to remove the 'omission by' column.***

15. ***Implement an electronic TAR, with associated electronic audit, by April 1, 2011.***

16. ***Revise the following audit forms to eliminate the 'omission by' section: Weekly TAR/Injection/Insulin Books, Restraint Flow Sheet, Flow Sheet; Monthly Resident Weight and Skin Assessment***

17. ***Discontinue the practice of the RN Supervisor sending 'action taken – follow-up letters' to individual RPN and PSW staff.***

[65] Performance evaluation of staff needs to be separated from the audit system. The IAC believes that the proposed modular system of care provision will enable assessment of performance as part of clinical leadership/supervision, without resorting to audits.

3.3.4 Nursing Leadership: Operational Issues

The IAC noted that one of the challenges of the current RN Supervisor role is that the RN Supervisor covers for a multitude of intra-facility operational 'gaps'. When the Schedulers are absent, the RN Supervisor calls RN, RPN and PSW staff for replacement; when supplies are needed, the RN Supervisor goes to the Nursing Storage Room for replacements; when the PSW can't locate the RPN on her Unit, the RN Supervisor is called on the cell phone for assistance, when keys are required to set up for an after-hours activity or event the RN Supervisor is responsible to open up the appropriate room etc. Constantly addressing these small operational non-nursing issues makes it more difficult for the RN Supervisor to focus on resident care issues. The IAC believes that revision to several operational issues will go a long way to improving the workload of the RN Supervisor.

Recommendations:

18. ***Increase the number of regular 'supply runs' from one (Wednesday night -Thursday) to two (Sunday night -Monday and Thursday night-Friday) to increase the likelihood of nursing supplies and medications being available throughout the week.***

19. ***Revise the Schedulers' hours to 0600-1400 hours and 1400 – 2200 hours to eliminate the current overlap in coverage from 1400 – 1800 hours in the afternoon and increase the hours of coverage to 2200 hours in the evening.***

20. ***Explore options for, and implement, a system to enhance intra-pod communication among the RPN and PSW staff , and between the RPNs and RN Supervisor within each pod (e.g. pod pagers, walkie-talkies etc).***

21. ***Review the current responsibilities for 'carrying the keys' to determine what keys can be carried by whom, to decrease the RN Supervisors' responsibility for non-nursing tasks.***

3.4 Culture and Communication

The IAC believes that culture and communication are closely inter-related. A culture that is based on trust, respect, openness and transparency, and that operates from a perspective of democratic shared-governance results (usually) in communications that are timely, effective and fulsome. A culture that is autocratic, focused on finding fault with top-down decision-making results (usually) in communications that are less than optimal.

Both Cassellholme and the Association referenced their disappointment with respect to the communication between and relationships with each other. Cassellholme was very disappointed in the Association's November 2009 letter to the Chair of the Management Board regarding professional practice issues at the Home, was even more disappointed with the Association's decision to approach the local media on this issue the week prior to the Hearing, and stated that relations between the Home and the Association are 'cordial at best'. The IAC understands that Cassellholme felt blindsided by the Association's corporate decision to make a public statement, but encourages the management team to recognize that the RN Supervisors were neither party to nor involved with this decision, and to not let this erode relationships at the local level.

The Association expressed their sense of a perceived lack of respect for nursing, due to the lack of involvement of the RN Supervisors in decisions regarding operations and practice, lack of response to feedback regarding (for example) audits, expectation that nurses will 'make do' with available resources without complaint etc. The IAC understood this perspective, in light of the apparent form-driven, bureaucratic and discipline-oriented culture at Cassellholme. The IAC encourages the Association to not abdicate involvement in and responsibility for identification and implementation of solutions.

The IAC believes that addressing communication opportunities relating to professional responsibility concerns and professional practice/operations will assist in developing a more cohesive, mutually respectful culture, will improve the perceived quality of work-life (and therefore workload) of the RN Supervisors and will, as a result, improve resident care.

3.4.1 Communication re Professional Responsibility Concerns

Section 10 of the Collective Agreement between Cassellholme and the Association is intended to provide a means for a constructive avenue for discussion regarding workload issues and/or concerns. There is no question that discussions regarding workload can at times be difficult, and that each side may feel frustrated with the lack of progress/change regarding the issues and by the perceived attitude of the other. In addition, given the small number of RNs within the bargaining unit at Cassellholme, and the fact that nurses in both the management and staff groups have worked together in various capacities for many years, the process of addressing issues can become personalized.

One of the challenges of the PRWRF system is that it provides for submission of forms regarding new specific events/shifts which relate to and/or based on long-term issues which do not have a quick fix … leading management to feel 'same old same old, certain people are never happy' and nurses to feel 'same old same old, no-one is listening'. A key element of successfully addressing professional responsibility concerns is that each side feels that the other understands and respects their position, that management acknowledges the challenges faced by RNs working in the midst of unresolved issues, and that the RNs acknowledge and support the steps that management is taking in an attempt to successfully address these same issues.

Although Section 10 provides for discussion of PRWRFs at the Union-Management Committee, the IAC believes that there is a role for ongoing informal discussion between the Bargaining Unit President and the Director of Clinical Services and Manager of Human Resources, outside of the formal Union-Management Committee structure. While this discussion cannot address specific PRWRFs, brainstorming and open discussion regarding major / long-term issues / 'the big picture' can only be beneficial, and may help to avoid rumours becoming issues becoming grievances.

The IAC also suggests that Cassellholme, the Association and the RNs consider development of a 'decision tree' to support the professional responsibility process. A decision tree, which outlines steps and considerations in the process, can facilitate discussion and will ensure key steps and decision/action points in the process are not missed.

Recommendation

22. ***Jointly (Cassellholme, the Association and the RN Supervisors) develop a 'Decision Tree for Workload Issues/Concerns' that outlines the steps in the professional***

responsibility concerns process, identify key steps and decision/action points, and ensure that issues are addressed.

3.4.2 Union-Management Meetings

The IAC was concerned with the apparent drop-off of Union-Management meetings over the past two years. Only one formal meeting occurred in 2009 (in April). Although a meeting appeared to have occurred in June, there was no agenda, no minutes and no evidence of discussion / agreement or actions taken. The IAC was also concerned that there did not appear to be an agreed upon process for how the agenda would be developed, by whom the meetings would be chaired, nor who would be responsible for the minutes etc.

Although the group at Cassellholme is small, this does not preclude the importance of structure and clearly identified accountabilities. The Union-Management Meeting is the formal mechanism through which issues are identified, strategies discussed, and agreements made re actions to be taken. Cancelling the meetings devalues the importance of this process. The IAC believes that both Cassellholme and the Association need to make a concerted effort to revitalize the Union-Management Meetings, to approach the discussions with an open mind and desire to find solutions, and to recognize both mutual accountability for the challenges that exist and responsibility to address them.

Recommendation

23. ***Cassellholme and the Association develop and implement Union-Management meeting parameters based on the following:***
    - a) ***Monthly meetings, with a minimum of 9 meetings per year, on a defined schedule determined in December of the year prior;***
    - b) ***Meetings chaired by Cassellholme and by the Association on a rotating basis;***
    - c) ***Chairperson for the upcoming meeting receive agenda items (including new and unresolved issues) from both Cassellholme and the Association and distribute the Agenda five working days in advance of the meeting;***
    - d) ***The first item of business at the meeting be Approval of the Agenda;***
    - e) ***Minutes be taken by Cassellholme and the Association on a rotating basis (when Cassellholme chairs, Cassellholme responsible for the minutes and vice versa), and be reviewed by that meeting's Chairperson before the next meeting;***
    - f) ***Minutes be posted in sufficient time to allow for agenda building for the next meeting;***
    - g) ***Minutes to reflect discussion and decisions at the current meeting, specify actions to be taken, accountability and report-back expectations; and***
    - h) ***Minutes posted in a mutually agreed location(s).***

3.4.3 Intra-Department Communication

The IAC understood that there are currently two regularly scheduled meetings between the Clinical Services management team and the RN Supervisors; a monthly RN Meeting, and a weekly Thursday morning meeting. In addition, the DCS holds individual quarterly meetings with the RPN and PSW staff, and three meetings per year with the RN/RPN nursing staff.

The monthly RN Meetings (and quarterly RPN and PSW) meetings are formally structured. The agenda is set by the DCS, who chairs the meeting; minutes are maintained and kept in a binder in her office. The Managers and all RN Supervisors (as available) attend. Health and safety is a standing agenda item. The meeting focuses on operational issues and is used to provide updates for example, on the rebuilding, new pharmacy services, policy changes etc. The Thursday morning meeting appears to be a hold-over from 2006, when the DCS met with the Nurse Managers to discuss staffing issues, discipline etc. There is no set agenda, and no minutes; the DCS reviews her calendar to update the RN Supervisors re recent/upcoming meetings (e.g. with the external pharmacy or other supplier), and the RN Supervisors attending cite operational issues (such as need for additional supplies). The RN Supervisors stated that the meeting tends to foster the separation between the 8-hour and 12-hour RN Supervisors, as it is largely attended by the 8-hour RNs and those who are not present do not know what was discussed.

The IAC recognizes the efforts the DCS is making to support communication by holding regular meetings by classification of staff, and believes that the weekly, monthly and quarterly meetings should continue, with an altered approach and focus. The IAC believes that there is a difference between meetings held for information sharing and addressing of operational issues and meetings held to discuss professional practice issues/opportunities. The IAC suggests that the weekly update meetings be maintained for sharing of information and discussion of operational issues, with those RN Supervisors working that day attending and minutes distributed by email to all the RN Supervisors via the portal. The IAC suggests that the current monthly RN and quarterly RPN meetings be combined into a Clinical Nursing Practice Committee, with a focus on gerontological nursing practice, and chaired by the Clinical Resource Nurse (see Section 3.4.5)

Recommendation:

24. ***The DSC or delegate (ADOC) hold weekly information sharing meetings***
    a) ***Time: does not conflict with care conference, MD rounds etc, to enable all RN Supervisors working that day to attend.***
    b) ***Purpose: sharing of information and discussion of Unit operational issues***
    c) ***Agenda: open (i.e. not developed in advance)***
    d) ***Minutes distributed via email on the portal to ADOCs and all RN Supervisors***

25. ***Clinical Nursing Practice Committee be struck, combining the previous monthly RN and quarterly RPN Meetings.***
    a) ***Purpose: Collaborative discussion and decision-making re best practices relating to gerontological nursing practice, including***
        i) ***implementation of best practice guidelines, with specific initial focus on implementation of BPG 'client centred care'***
        ii) ***review of audit trends and outcomes and identification of required changes in policy/practice to address issues identified***
    b) ***Chair: Clinical Resource Nurse***
    c) ***Membership: ADOCs, 3 RN Supervisors, 3 RPNs, selected by nomination with a 2-year term***
    d) ***Meetings: monthly, at least 9 per year***
    e) ***Agenda: developed by Chair and circulated 5 working days in advance***
    f) ***Minutes: document discussion of issues, actions agreed upon, timelines and accountability for follow-up; distributed to all RNs/RPNs via portal.***

SECTION IV

CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusion

The IAC was requested to specifically address the issue of whether or not the RN Supervisors at Cassellholme are being requested to perform more work than is consistent with proper patient care.

Through a comprehensive process involving review of written and oral submissions, focused discussion at a 2-1/2 day hearing and extensive Committee analysis and discussion following the Hearing, the IAC concluded that the current organization structure, corporate culture and role responsibilities of staff within the Clinical Services Department do not support effective implementation of the RN Supervisor role.

The IAC believes that RN workload is influenced by client (e.g. complexity of bio-psycho-social care needs, cultural, emotional and health learning needs), nurse e.g. nurse-resident ratio, roles and responsibilities of care providers) and environmental (e.g. practice supports, consultation resources, physical environment of practice) factors.

The IAC found that the resident care needs at Cassellholme are consistent with those in other Municipal Homes for the Aged, and believes that client factors are not negatively impacting the workload of the RN Supervisors.

With respect to nurse factors, the IAC believes that the RN Supervisor workload will be significantly positively impacted by

- revising the care delivery model to a ‘pod’ approach, with designated RN Supervisors responsible for the delivery of care to a specific group of residents by consistent RPNs and PSWs,
- implementing consistent role responsibilities for all full-time RN Supervisors, including operational accountability for resident care within assigned pod(s), and revised responsibilities for performance review and audit completion, and
- implementing a Clinical Resource Nurse (CRN) role, on at least a term basis, to provide clinical leadership in the implementation of selected Best Practice Guidelines.

The IAC believes that the RN Supervisor role will be positively impacted by changes to a number of environmental factors

- revising the Client Services Department organizational/leadership structure to provide for line accountability of all members of the management team,
- implementing a comprehensive recruitment and retention strategy promoting a quality workplace practice environment,
- revising audit requirements, including implementation of an electronic MAR and TAR, and
- developing and implementing more consistent communication strategies to address professional responsibility concerns and intra-Department operations.

The IAC is very aware that a number of its recommendations relating to human resources (staffing and scheduling) appear to have a fiscal impact, and recognizes that Cassellholme has finite resources within its nursing care envelope. However, the IAC does not believe that additional fiscal resources will be required.

The IAC believes that the majority (if not all) of the costs for the additional recommended RN Supervisor and RPN FTEs can be covered through reallocation of monies currently within the Cassellholme budget. Currently, the vast majority of replacement costs for illness and other absences are covered by premium pay and/or overtime. The IAC believes that implementation of the pod approach to care delivery, clear and consistent role responsibilities for the RN Supervisor, and enhanced intra-Department communication and decision-making will result in a more positive work environment resulting in significantly less RN, RPN and PSW sick time, which, if covered by part-time staff at straight rather than premium time, will realize significant cost savings. In addition, the IAC believes that Cassellholme will be able to utilize creative strategies to fund part or all of the CRN position.

The IAC strongly believes that implementation of these recommendations will have a very positive impact on the quality of the work-life environment, with a cascading positive impact on the quality of resident care and MOHLTC compliance. The IAC encourages Cassellhome and the Association to work together to achieve these recommendations, and to evaluate their impact using a framework such as the CNA Framework to Determine the Impact of Nursing Staff Mix Decisions (2005)[66].

4.2 Summary of Recommendations

The IAC identified 25 recommendations relating to roles and responsibilities, leadership and quality care, and communication and culture.

Roles and Responsibilities:

1. Implement a care delivery model whereby a designated group RPNs and PSWs are consistently accountable for the provision of care to residents within one of nine pods, with leadership provided by an RN Supervisor dyad.

2. Discontinue the current functional approach to role responsibilities (i.e. 'daily bath PSW' or 'treatment RPN').

3. Implement a consistent leadership role for all full-time RN Supervisors, with accountability and responsibility for clinical and operational leadership of designated pods shared between 2-person dyads:
   - one dyad responsible for the four pods on Apple and Maple (total 97 residents)
   - one dyad responsible for the three pods on Birch (total 71 residents)
   - one dyad responsible for the two pods on Willow (total 72 residents).

4. Implement a consistent (i.e. not combined) schedule for the RN Supervisors whereby the RN Supervisors are accountable, in dyad pairs, for the provision of resident care, quality of care, staff performance and smooth operational functional functioning of a the pods within a designated Unit(s) (Apple/Maple, Cherry Lane/Birch or Willow).

[66] www.can-aiic.ca/CAN/documents/pdf/…**Evaluation_Framework**_2005_e.pdf

5. Replace the term ‘performance appraisal’ with ‘performance review’.

6. Revise the performance review form used for RPNs and PSWs to include completion of an assessment and identification of learning needs/goals by the RPN/PSW and a review by the RN Supervisor.

7. Revise the performance review process to include two distinct steps:
   a) RN Supervisor to discuss with RPN/PSW the similarities/differences between the RPN’s/PSW’s self-assessment and RN Supervisor’s review, and identify strengths / areas requiring development and learning needs/goals;
   b) Director of Client Services or delegate to assess the above documentation, summarize required next steps, take action with the RPN/PSW as required, and sign to formalize the performance review.

8. The full-time RN Supervisors work in pairs to implement the following Clinical Practice Guidelines, accessing the resources available through the Best Practices Toolkit:
   - Continence and constipation: assessment and management
   - Falls prevention and management
   - Pain assessment and management, and
   - Pressure ulcer risk prevention, assessment and management.

9. Implement a Clinical Resource Nurse Role for a two-year term period, beginning September 1, 2010. Decision regarding continuation of the role be based on a joint evaluation, by Cassellholme and the Association, of the role’s impact and effectiveness on
   a) Resident quality of care
   b) Resident resident/family satisfaction, and
   c) RN/RPN retention.

Leadership and Quality Care:

10. Revise the reporting relationships within the Clinical Services Department to provide a manageable span of control and articulate the line accountabilities of the three members of the Clinical Services Management Team. Specifically:
    a) Manager title be changed to Assistant Director of Care (ADOC)
    b) Each ADOC to maintain current project accountability, and assume line accountability for two Units (Apple/Maple or Birch/Willow)
    c) RNs, RPNs, PSWs and Unit Assistants to report directly to the ADOC
    d) Director to retain direct reporting relationship Schedulers, Resident Services Coordinator, Restorative Therapists and Physiotherapy staff.

11. The Clinical Services Management Team implement the RNAO healthy work environment best practice guideline Developing and Sustaining Effective Staffing and Workload Practices in 2010 and the best practice guideline Developing and Sustaining Nursing Leadership in 2011.

12. Cassellholme develop a formal short-term recruitment strategy, which is evaluated q6 months in terms of numbers of staff recruited and ongoing vacancy rate, and includes:
    a) expanded marketing, with use of campus/job fairs, internet posting sites

(government, professional association, interest groups etc), municipal posting sites etc;

b) exploration of creative recruitment approaches, such as the Two Jobs in One strategy developed by OANHSS;

c) evaluation and revision as required of the hiring process, and the orientation program.

13. Cassellholme develop a retention plan which addresses scheduling and quality of work-life issues, including:
   a) Implementing a schedule which provides for
      i) equal role responsibilities and opportunities for the full-time RN Supervisors;
      ii) availability of part-time RN Supervisors to cover anticipated and unanticipated short and long term vacancies (i.e. the total 45-hour commitment not be pre-booked on the master rotation) thus decreasing the need to frequently request full and part-time RNs to accept extra shifts;
      iii) consistent coverage of the shifts within the master rotation, to decrease the RNs' sense that they are 'working short' approximately 50% of the time; and
      iv) opportunity for part-time RN Supervisors to indicate dates for which they are unavailable for personal reasons.
   b) Discontinuing the unspoken message that staffing problems are the staff's (not management's) fault by
      i) altering the staffing statistics categories by eliminating 'NAV', 'sick days
      ii) combined', and 'unwilling to work on day off'; and
   c) revising Section 5.2 of the Attendance Management Program;
   Developing the RN Supervisor role responsibilities to enhance involvement in clinical and operational decision-making, provide opportunity for teaching, and articulate accountability for development of areas of clinical expertise (e.g. best practice guideline implementation), so that the RN role at Cassellholme mirrors the elements that new graduates are being taught. These elements of best practice are important within the practice and profession of nursing, and new graduates are looking for and expecting this practice in organizations today when they seek employment.

14. Implement an electronic MAR with associated electronic audit, by October 1, 2010, with the goal of the audit to identify the impact of missing medications on resident care. In the meantime, revise the Weekly MAR audit to remove the 'omission by' column.

15. Implement an electronic TAR, with associated electronic audit, by April 1, 2011.

16. Revise the following audit forms to eliminate the 'omission by' section: Weekly TAR/Injection/Insulin Books, Restraint Flow Sheet, Flow Sheet; Monthly Resident Weight and Skin Assessment

17. Discontinue the practice of the RN Supervisor sending 'action taken – follow-up letters' to individual RPN and PSW staff.

18. Increase the number of regular 'supply runs' from one (Wednesday night -Thursday) to two (Sunday night -Monday and Thursday night-Friday) to increase the likelihood of nursing supplies and medications being available throughout the week.

19. Revise the Schedulers' hours to 0600-1400 hours and 1400 – 2200 hours to eliminate the current overlap in coverage from 1400 – 1800 hours in the afternoon and increase the hours of coverage to 2200 hours in the evening.

20. Explore options for, and implement, a system to enhance intra-pod communication among the RPN and PSW staff , and between the RPNs and RN Supervisor within each pod (e.g. pod pagers, walkie-talkies etc).

21. Review the current responsibilities for 'carrying the keys' to determine what keys can be carried by whom, to decrease the RN Supervisors' responsibility for non-nursing tasks.

Culture and Communication:

22. Jointly (Cassellholme, the Association and the RN Supervisors) develop a 'Decision Tree for Workload Issues/Concerns' that outlines the steps in the professional responsibility concerns process, identify key steps and decision/action points, and ensure that issues are addressed.

23. Cassellholme and the Association develop and implement Union-Management meeting parameters based on the following:
    a) Monthly meetings, with a minimum of 9 meetings per year, on a defined schedule determined in December of the year prior;
    b) Meetings chaired by Cassellholme and by the Association on a rotating basis;
    c) Chairperson for the upcoming meeting receive agenda items (including new and unresolved issues) from both Cassellholme and the Association and distribute the Agenda five working days in advance of the meeting;
    d) The first item of business at the meeting be Approval of the Agenda;
    e) Minutes be taken by Cassellholme and the Association on a rotating basis (when Cassellholme chairs, Cassellholme responsible for the minutes and vice versa), and be reviewed by that meeting's Chairperson before the next meeting;
    f) Minutes be posted in sufficient time to allow for agenda building for the next meeting;
    g) Minutes to reflect discussion and decisions at the current meeting, specify actions to be taken, accountability and report-back expectations; and
    h) Minutes posted in a mutually agreed location(s).

24. The DSC or delegate (ADOC) hold weekly information sharing meetings
    a) Time: does not conflict with care conference, MD rounds etc, to enable all RN Supervisors working that day to attend.
    b) Purpose: sharing of information and discussion of Unit operational issues
    c) Agenda: open (i.e. not developed in advance)
    d) Minutes distributed via email on the portal to ADOCs and all RN Supervisors

25. Clinical Nursing Practice Committee be struck, combining the previous monthly RN and quarterly RPN Meetings.
    a) Purpose: Collaborative discussion and decision-making re best practices relating to gerontological nursing practice, including
        i) implementation of best practice guidelines, with specific initial focus on implementation of BPG 'client centred care'

ii) review of audit trends and outcomes and identification of required changes in policy/practice to address issues identified

b) Chair: Clinical Resource Nurse
c) Membership: ADOCs, 3 RN Supervisors, 3 RPNs, selected by nomination with a 2-year term
d) Meetings: monthly, at least 9 per year
e) Agenda: developed by Chair and circulated 5 working days in advance
f) Minutes: document discussion of issues, actions agreed upon, timelines and accountability for follow-up; distributed to all RNs/RPNs via portal..

October 6, 2009 ***Appendix 1***

Joan Edwards Cardiff
306 Freedom Private
Ottawa, ON K1G 6W4

By Email

Dear Ms. Cardiff,

Re: Cassellholme East Nipissing District Home for the Aged: Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – OUR FILE # 252270

In accordance with Article 10.01 of the collective agreement between the parties, the Union Management Committee has met on several occasions, to hear and attempt to resolve the professional responsibility workload concerns for the RN. Failing resolution of the workload concerns to this time the union is forwarding this matter to the Independent Assessment Committee.

With this letter Ontario Nurses' Association (ONA) is referring the unresolved concerns specified below to the Independent Assessment Committee (IAC) for review and recommendations:

> The Employer assigned duties to the RNs in Supervisor Role in the areas of clinical, administrative, and educational responsibilities is more work than is consistent with proper resident care. ONA finds the Employer has not addressed concerns relative to:

1. Clinical Responsibilities: inappropriate patient assignment, inadequate organization wide base staffing, and working short staffed due to limited staff availability.
2. Administrative Responsibilities: high volume of documentation and chart audits, high proportion of evaluative documentation for implementation of quality improvements due to MOHLTC unmet standards and areas of non-compliance.
3. Educational Responsibilities: added responsibilities of completing probation and performance appraisal for all staff in supporting staff learning and development by providing guidance and education.

ONA respectfully submits this Professional Responsibility Complaint to the IAC and accepts the hearing dates of December 15, 16 and 17, 2009. ONA will provide the IAC with our submission by November 27, 2009 as required to give you adequate review time.

We thank you for your assistance in this matter.

Sincerely,
ONTARIO NURSES' ASSOCIATION

Mariana Markovic

Mariana Markovic
LRO, Professional Practice Specialist

mm/al

C:

Brenda Loubert, Administrator, Cassellholme
Cindy Ross, Director of Clinical Service, Cassellholme
Lise Ellis, Human Resources Manager, Cassellholme
Ric Campbell, Director of Finance, Cassellholme
Christine Byrnes, Bargaining Unit President, ONA Local
Carolyn Prepp, Labour Relations Officer, ONA

December 6, 2009 ***Appendix 2***

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms. Jo Anne Shannon
Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms. Shannon :

Re : Cassellholme East Nipissing District Home for the Aged and Ontario Nurses' Association : Professional Responsibility Complaint – Independent Assessment Committee Hearing

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Cassellholme East Nipissing District Home for the Aged and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held at the Cassellholme, East Nippising District Home for the Aged on Tuesday February 9th, Wednesday February 10th and Thursday February 11th, 2010, as per the attached Hearing Agenda.

The IAC will tour the Home on the morning of Tuesday February 9th, 2010, prior to the Hearing. The Tour will begin at 1000 hours. I am requesting that the Ontario Nurses' Association work with Cassellholme East Nipissing District Home for the Aged to coordinate the arrangements for the tour. Please jointly decide:

- how many ONA and Cassellholme representatives will accompany the three IAC members on the tour, and who these representatives will be,
- what areas of Cassellholme will be included in the tour, and
- who will lead the tour.

Please ensure that I receive this information by Friday January 29th, 2010.

The Hearing will begin at 1300 hours on Tuesday February 9th, 2010. As indicated on the Hearing Agenda, each of the Ontario Nurses' Association and Cassellholme East Nipissing District Home for the Aged will have one and one half (1-1/2) hours to present their submission. If you plan to use a powerpoint presentation, please bring your own laptop. The afternoon will adjourn following presentation of both submissions, in order to enable each party to prepare their Reply.

The Hearing will recommence on the morning of Wednesday February 10th, with the Reply from Cassellholme East Nipissing District Home for the Aged, followed by the Reply from the Ontario Nurses' Association. The Hearing will adjourn following presentation of both Reply submissions; the time of adjournment will depend on the extent of discussion required. The IAC will meet following the Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on the morning of Thursday February 11th, with Questions to both the Ontario Nurses' Association and Cassellholme East Nipissing District Home for the Aged by the IAC. The Hearing is currently scheduled to close at 1300 hours on Thursday February 11th; if additional time is required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

I have requested that the Hearing be held at the Cassellholme East Nipissing District Home for the Aged. Refreshments will be available in the morning and afternoon, but lunch will not be provided. I have requested the Home to provide a caucus room for the Ontario Nurses' Association for the three days (i.e. 0900 Tuesday February 9th to 1600 Thursday February 11th).

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by the close of business day (1600 hours) on Friday January 22, 2010. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments by courier on Monday January 25th, 2010 as follows:

- one (1) copy of the Cassellholme submission and one (1) copy of the ONA submission to Colleen Harrington-Piekarski (Home for the Aged Nominee);
- one (1) copy of the Cassellholme submission and one (1) copy of the ONA submission to Janet Matthews (ONA Nominee);
- two (2) copies of the Cassellholme submission to the ONA (attention Jo Anne Shannon);
- two (2) copies of the ONA submission to Cassellholme East Nipissing District Home for the Aged (attention Lise Ellis).

In the event that the Ontario Nurses' Association wishes to provide supplemental information after January 22nd, 2010, supplemental information will be accepted to the close of business (1600 hours) on Friday January 29th, 2010 only. Supplemental information will be distributed by the IAC Chairperson as above. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Ontario Nurses' Association presentation; it is not information to respond to the Cassellholme East Nipissing District Home for the Aged submission.

The IAC will meet the week of February 1st, 2010 to review the submissions in detail in advance of the Hearing.

The Independent Assessment Committee looks forward to working with you to address the professional responsibility issues of concern. In the meantime, if you have any questions, please contact me by phone at 613-260-2415 or 613-622-7743 or by email at jcardiff@cheo.on.ca.

Sincerely

Joan Cardiff
Chair, Independent Assessment Committee

cc. Colleen Harrington-Piekarksi (Home for the Aged Nominee)
Janet Matthews, ONA Nominee
Lise Ellis, Manager Human Relations, Cassellholme East Nipissing District Home

December 6, 2009 ***Appendix 2***

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms. Lise Ellis
Human Resources Manager
Cassellholme, East Nipissing District Home for the Aged
400 Olive Street
North Bay, Ontario
P1B 6J4

Dear Ms Ellis:

Re : Cassellholme, East Nipissing District Home for the Aged and Ontario Nurses' Association : Professional Responsibility Complaint – Independent Assessment Committee Hearing

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Cassellholme, East Nipissing District Home for the Aged and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held at the Cassellholme, East Nippising District Home for the Aged on Tuesday February 9th, Wednesday February 10th and Thursday February 11th, 2010, as per the attached Hearing Agenda.

The IAC will tour the Home on the morning of Tuesday February 9th, 2010, prior to the Hearing. The Tour will begin at 1000 hours. I am requesting that Cassellholme East Nipissing HA work with the Ontario Nurses' Association to coordinate the arrangements for the tour. Please jointly decide:

- how many Cassellholme and ONA representatives will accompany the three IAC members on the tour, and who these representatives will be,
- what areas of Cassellhome will be included in the tour, and
- who will lead the tour.

Please ensure that I receive this information by Friday January 29th, 2010.

The Hearing will begin at 1300 hours on Tuesday February 9th, 2010. As indicated on the Hearing Agenda, each of the Ontario Nurses' Association and Cassellholme East Nipissing Home for the Aged will have one and one half (1-1/2) hours to present their submission. The afternoon will adjourn following presentation of both submissions, in order to enable each party to prepare/finalize their Reply.

The Hearing will recommence on the morning of Wednesday February 10th, with the Reply from Cassellholme East Nipissing Home for the Aged, followed by the Reply from the Ontario Nurses' Association. The Hearing will adjourn following presentation of both Reply submissions; the time of adjournment will depend on the extent of discussion required. The IAC will meet following the Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on the morning of Thursday February 11th, with Questions to both the Ontario Nurses' Association and Cassellholme East Nippising Home for the Aged by the

IAC. The Hearing is currently scheduled to close at 1300 hours on Thursday February 11th; if additional time is required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by the close of business day (1600 hours) on Friday January 22, 2010. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments by courier on Monday January 25th as follows:

- one (1) copy of the Cassellholme East Nipissing Home for the Aged submission and one (1) copy of the Ontario Nurses' Association submission to Colleen Harrington-Piekarski (Home for the Aged Nominee);
- one (1) copy of the Cassellholme East Nipissing Home for the Aged submission and one (1) copy of the Ontario Nurses' Association submission to Janet Matthews (ONA Nominee);
- two (2) copies of the Cassellholme East Nipissing Home for the Aged submission to the Ontario Nurses' Association (attention Jo Anne Shannon); and
- two (2) copies of the Ontario Nurses' Association submission to Cassellholme East Nipissing Home for the Aged (attention Lise Ellis).

In the event that Cassellholme East Nipissing Home for the Aged wishes to provide supplemental information after January 22nd, 2010, supplemental information will be accepted to the close of business (1600 hours) on Friday January 29th, 2010. Supplemental information will be distributed by the IAC Chairperson as above. Supplemental information will not be accepted after this date. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Cassellholme East Nipissing Home for the Aged presentation; it is not information to respond to the Ontario Nurses' Association submission.

The IAC will meet the week of February 1st, 2010 to review the submissions in detail in advance of the Hearing.

The IAC would prefer to hold the Hearing at the Home for the Aged, as this will enable a larger number of Registered Nurses to attend the Hearing as participants or observers. We will require the following 'logistical support':

- Hearing and IAC:
    - Use of the Boardroom/large Conference Room for the full three day period (0900 Tuesday February 9th to 1600 Thursday February 11th)
        - Please configure the table in a U-shape, with 3 seats (for the IAC) at the head of the table, and 10 seats on either side.
        - Please ensure that an extension cord is available if an electrical plug is not close to the IAC (I will be using a laptop).
        - Please provide an LCD projector and flipchart.
        - Please ensure that the IAC has access to a printer after regular business hours (i.e. into the evening) on Tuesday February 9th and Wednesday February 10th.

- Caucus room
    - Please provide a caucus room for the ONA team for the full three day period (0900 Tuesday February 9th to 1600 Thursday February 11th), with seats for 10 people, and if at all possible, telephone and internet access.
    - Note: The IAC will use the Boardroom as a caucus room when the Hearing is not in session.
    - If the Cassellholme team also requires a caucus room, please ensure it is made available.

- Catering:
    - Please arrange for tea, coffee, juices and water to be available in the Boardroom for all times that the Hearing is in session. Please provide muffins for the morning break on Wednesday and Thursday, and cookies/fruit for the afternoon break on Tuesday and Wednesday.
    - Please arrange for tea, coffee and water to be available in the ONA caucus room over the full three days
    - Please provide a working lunch for the three IAC members on all three days (Tuesday February 9th through Thursday February 11th) in the Boardroom.

The Independent Assessment Committee looks forward to working with you to address the professional responsibility issues of concern. In the meantime, if you have any questions, or would like to discuss any of the 'logistical support' requirements, please contact me by phone at 613-260-2415 or 613-622-7743 or by email at jcardiff@cheo.on.ca.

Sincerely

Joan Cardiff
Chair, Independent Assessment Committee

cc. Colleen Harrington-Piekarski, Home for the Aged Nominee
Janet Matthews, ONA Nominee
Jo Anne Shannon, Professional Practice Specialist, ONA

February 6, 2010 *Appendix 3*

306 Freedom Private **BY EMAIL**
Ottawa, Ontario
K1G 6W4

Ms. Lise Ellis
Human Resources Manager
Cassellholme East Nipissing District Home for the Aged
400 Olive Street
North Bay, Ontario
P1B 6J4

Dear Ms Ellis:

Re : Cassellholme East Nipissing District Home for the Aged and Ontario Nurses' Association : Professional Responsibility Complaint – Independent Assessment Committee Hearing

The Independent Assessment Committee (IAC) held a Pre-Hearing Meeting in North Bay on February 4th and 5th. We reviewed the Briefs and Exhibits submitted by Cassellholme East Nipissing District Home for the Aged and the Ontario Nurses' Association. We recognize the significant time and energy that preparation of this material entailed, and appreciate the detailed information provided. Our review identified a number of areas for which we require additional information.

I am writing to request the following:

Organization Chart and Job Descriptions

- We would like to see an organization chart for the Home and the Clinical Services Department, and job descriptions for the Clinical Services staff.
- We are interested in the reporting and working relationships between the RN Supervisors and the Director of Clinical Services, the Infection Control/Documentation Manager, the Manager of Clinical Standards, the TSS ET Nurse, and the RPNs and PSWs.

RAI scores for 2009 and 2008

- We would like to see any information available regarding RAI assessments, in order to gain a more detailed understanding of the care requirements of the residents.
- We would also like to better understand the roles of the RPNs, RN Supervisors and RAI Coordinators with respect to completion and analysis of the RAI assessments.

A complete package of the current audit forms

- A large number of audit forms were included in both the Cassellholme and ONA exhibits, some of which were not consistent. In addition, there have been a number of changes to the audit process over the past months. We would like to clearly understand the current audit requirements, including
  - which forms are currently in use,
  - by whom and when they are completed,
  - by whom and when the 'raw' audit forms are analyzed, and

  - o to whom this information is reported (in addition to the MOH-LTC).

<u>Reports and Policies</u>

- We would like to see data regarding the following for 2009:
  - ‘general’ incidents (the incident forms themselves and/or any analyzed data)
  - falls
  - medication events (ie errors, omissions, adverse events)
  - resident and family feedback
- We would like a copy of the current restraint policy, and any information (such as memos, meeting minutes etc) regarding the use of restraints within Cassellholme.

<u>Attendance</u>

- Exhibit 21 of the Cassellholme submission included information regarding the number of days of sick time across the RN, RPN and PSW groups, as well as information regarding OT hours incurred during 2009. In order to understand the issues of sick time and overtime more completely, we would like to see the following for the RN, RPN and PSW groups for 2009:
  - Total number of sick time hours (rather than number of days),
  - Total number of worked hours,
  - Total number of overtime hours (i.e. those paid at premium time). We recognize that this will also include incremental overtime – i.e. missed breaks, additional time at end of shift etc. It is not necessary to break this out
  - Total number of paid hours.

<u>Schedulers</u>

- We would like to understand the role and hours of work of the Schedulers, in order to understand the scope of their responsibilities, in relation to those of the RN Supervisors, with respect to day-to-day staffing.

We recognize that some of this information will be readily available and some will take some time to prepare. Please provide whatever information is possible by the beginning of the Hearing (1300 Tuesday February 9th), and the remainder by 1600 on Wednesday February 10th. Please provide copies for both the IAC and ONA.

With respect to the Tour on Tuesday February 9th, we would appreciate having a layout diagram of Cassellholme as we walk around. This can be a hand-drawn floor plan, or architectural plans, or whatever is easily available, to enable us to gain a firm idea of the lay-out and location of units/supply areas/dining rooms etc across the three floors.

We are looking forward to meeting with you and the Cassellholme team on Tuesday. If you have any questions in the meantime, please contact me at 613-697-8884 (cell) or email.

Sincerely

Joan Cardiff
Independent Assessment Committee Chair

cc. Jo Anne Shannon, Professional Practice Specialist, ONA
Janet Matthews, ONA Nominee
Colleen Piekarski, Cassellholme Nominee

Appendix 3

February 6, 2010

BY EMAIL

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms. Lise Ellis
Human Resources Manager
Cassellholme East Nipissing District Home for the Aged
400 Olive Street
North Bay, Ontario
P1B 6J4

Ms Jo Anne Shannon
LRO, Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street
Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms. Ellis and Ms Shannon :

Re : Cassellholme East Nipissing District Home for the Aged and Ontario Nurses' Association : Professional Responsibility Complaint – Independent Assessment Committee Hearing

The Independent Assessment Committee met on February 4th and 5th, 2010 to prepare for the IAC Hearing scheduled for February 9th – 11th, 2010.

We reviewed the Briefs and Exhibits submitted by Cassellholme East Nipissing District Home for the Aged and the Ontario Nurses' Association in detail; the scope and depth of information provided enabled us to gain an initial understanding of the workload issues in question.

We note that the three RN Supervisors who will be attending the Hearing (Christine Byrnes, Christine Hildreth and Gail Powers) all work a 12-hour schedule. In light of the fact that 50% of the full-time nurses work an 8-hour schedule, we believe it will be important to gain the perspective of an "8-hour RN" as well.

I am writing to request that provision be made for the attendance of one of the full-time nurses working an 8-hour schedule as a Participant at the Hearing, at the least for Thursday morning, and optimally for Wednesday as well.

I recognize that this request is being made at very short notice, and appreciate the resulting scheduling challenges. However, in order to achieve the outcomes of the IAC process that we are all seeking, the Committee believes it essential that this perspective be made available in person.

We are looking forward to meeting with the Cassellholme and ONA teams on Tuesday. If you have any questions in the meantime, please contact me at 613-697-8884 (cell) or by email.

Sincerely,

Joan Cardiff
Independent Assessment Committee Chair

cc Janet Matthews, ONA Nominee
Colleen Piekarski, Cassellholme Nominee

Appendix 4

Independent Assessment Committee Hearing

Ontario Nurses' Association
and
Cassellholme East Nipissing District Home for the Aged

Agenda

Tuesday February 9, 2010

09:00 – 10:00	*Independent Assessment Committee Meeting (Committee members only)*
10:00 – 12:00	Tour of Cassellholme East Nipissing District Home for the Aged ◆Attending: ·Independent Assessment Committee ·For the Home for the Aged: To be determined ·For the Association: Christine Byrnes, Christine Hildreth, Jo Anne Shannon
13:00	**Commencement of Hearing**
13:00 – 13:15	◆Introduction and Review of Proceedings by Chairperson
13:15 – 14:45	◆Ontario Nurses' Association Submission Presentation ◆Response to questions of clarification from ·Independent Assessment Committee ·Cassellholme East Nipissing District Home for the Aged
14:45 – 15:15	Break
15:15 – 16:45	◆Cassellholme East Nipissing District Home for the Aged Submission Presentation ◆Response to questions of clarification from ·Independent Assessment Committee ·Ontario Nurses' Association
16:45 – 17:00	◆Review of Process for February 10, 2010 by Chairperson
17:00	Adjournment of Hearing

Independent Assessment Committee Hearing

Ontario Nurses' Association and Cassellholme East Nipissing District Home for the Aged

Agenda

Wednesday February 10, 2010

08:00 – 09:00	*Independent Assessment Committee Meeting (Committee members only)*
09:00	Continuation of Hearing
09:00 – 12:00	◆Cassellholme East Nipissing District Home for the Aged Response to Ontario Nurses' Association Submission ◆Response to questions from ·Independent Assessment Committee ·Ontario Nurses' Association ◆Discussion
12:00 – 13:00	Lunch Break
13:00 – 16:00	◆Ontario Nurses' Association Response to Cassellholme East Nipissing District Home for the Aged Submission ◆Response to questions from ·Independent Assessment Committee ·Cassellholme East Nipissing District Home for the Aged ◆Discussion
16:00 – 16:15	◆Review of Process for February 11, 2010 by Chairperson
16:15	Adjournment of Hearing
16:30 – 20:30	*Independent Assessment Committee Meeting (Committee members only)*

Note: The timing of the agenda is 'fluid'. If the Cassellholme Response discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response discussion concludes before the end of the day, we will proceed with the IAC Questions. The Hearing will adjourn at 1630 at the latest.

Independent Assessment Committee Hearing

Ontario Nurses' Association
and
Cassellholme East Nipissing District Home for the Aged

Agenda

Thursday February 11, 2010

08:30	Continuation of Hearing
08:30 – 12:30	◆Questions to both Parties by Independent Assessment Committee
12:30 – 13:00	◆Closing Remarks and Identification of Next Steps by Chairperson
13:00	**Closure of Hearing**
13:00 – 14:00	*Independent Assessment Committee Meeting (Committee members only)*

Appendix 5

Hearing Participants and Observers

Tuesday February 9, 2010

Hearing Participants:

For the Association:
- Christine Byrnes, Bargaining Unit President
- Linda Guillena, RN Supervisor
- Rozanna Haynes, Professional Practice Specialist
- Christine Hildreth, RN Supervisor
- Jo Anne Shannon, Professional Practice Specialist

For Cassellholme:
- Lise Ellis, Human Resources Manager
- Ward Jones, Labour Relations Consultant
- Brenda Loubert, Administrator
- Cindy Ross, Director of Care
- Cheryl Sheppard, Manager of Clinical Standards

Hearing Observers:

For the Association:
- Lorrie Daniels, Professional Practice Specialist
- Kathryn Jordan, RN Supervisor
- Diana Kutchaw, Labour Relations Officer, Sudbury
- Debbie McCrank, Regional Co-ordinator, Kirkland Lake
- Marg McGillis, RN Supervisor
- Gail Powers, RN Supervisor
- Carolyn Prepp, Labour Relations Officer, Timmins

Wednesday February 10, 2010

Hearing Participants:

For the Association:
- Christine Byrnes, Bargaining Unit President
- Rozanna Haynes, Professional Practice Specialist
- Christine Hildreth, RN Supervisor
- Jo Anne Shannon, Professional Practice Specialist

For Cassellholme:
- Lise Ellis, Human Resources Manager
- Ward Jones, Labour Relations Consultant
- Brenda Loubert, Administrator
- Cindy Ross, Director of Care
- Cheryl Sheppard, Manager of Clinical Standards

Hearing Observers:

For the Association:

- Lorrie Daniels
- Diana Kutchaw, Labour Relations Officer, Sudbury
- Gail Powers, RN Supervisor
- Carolyn Prepp, Labour Relations Officer, Timmins

Thursday February 11, 2010

Hearing Participants:

For the Association:

- Christine Byrnes, Bargaining Unit President
- Rozanna Haynes, Professional Practice Specialist
- Christine Hildreth, RN Supervisor
- Jo Anne Shannon, Professional Practice Specialist

For Cassellholme:

- Lise Ellis, Human Resources Manager
- Ward Jones, Labour Relations Consultant
- Brenda Loubert, Administrator
- Cindy Ross, Director of Care
- Cheryl Sheppard, Manager of Clinical Standards

Hearing Observers:

For the Association:

- Fran Corrigan, RN Supervisor
- Lorrie Daniels, Professional Practice Specialist
- Diana Kutchaw, Labour Relations Officer, Sudbury
- Carolyn Prepp, Labour Relations Officer, Timmins

Email sent March 14, 2010

Appendix 6

Hello Brenda, Lise, Cindy and Ward

I am writing in follow-up to the IAC's meeting on March 4-5th. At that time, we identified a number of specific issues on which we require further clarification.

1. Phase I Renewal Strategy Funding:
Will the Phase I Renewal Strategy funding, announced on Feb 5th, involve the addition of more beds for Cassellholme, or will it involve infrastructure improvements for the current 240 beds? If there will be an increase in beds -- how many?

2. Schedulers
Please reconfirm the Schedulers' schedule. We believe they work 0600 - 1400 and 1400 - 2200 Monday through Friday, 1000 - 1400 Saturday and not at all on Sunday. Is this correct?

3. ONA Sick Time
During the Hearing, we had discussion regarding the statistics included in Cassellholme's Exhibit 21 relating to the ONA RNs. Please confirm the following:
Is the 154 'sick days combined' a total of paid sick days, unpaid sick days and unpaid sick days not scheduled, as indicated? Or is the 154 sick days only paid sick days?
What are the actual number of hours of ONA RN sick time during 2009? (5 "days" sick time for an RN working 12-hour shifts is very different from 5 "days" sick time for RNs working 8-hr shifts.)
Can you provide a breakdown re # sick hours for full-time and part-time RNs

4. Staff Attendance/Absence
Also referring to Exhibit 21, please confirm that the total number of shifts for which the RPNs were absent, for all reasons, in 2009 was 1303, and for PSWs was 3799. If this is incorrect, please provide the correct totals by category of absence.
In our February 6, 2010 letter, we asked that the following be provided for the RN, RPN and PSW groups:
- total number of sick time hours (#3 above)
- total number of worked hours
- total number of overtime hours (hours paid at premium time, regardless of reason)
- total number of paid hours

We still wish to receive this information.

5. Overtime
Also referring to Exhibit 21, the tables titled "ONA Attendance Issues", the number of overtime hours was markedly higher from August to November inclusive -- what was the reason for this?

6. Summer Schedule
During the Hearing, both Cassellholme and the Association referred to a 'gentlewoman's agreement' that the schedule would be routinely short one day RN in order to provide vacation during the summer. Was this just for 2009, or also for 2008 and prior?

7. RAI Coordinators
Please explain the role of the RAI Coordinators. We understood that the RNs/RPNs are completing the RAI/RAP care plan -- is this correct? If so, what are the RAI Coordinators' responsibilities?

8. RPN Team Leaders
During the period 2006 to 2007 when the RPN Team Leaders were in place, were they located on each of Apple, Maple, Birch and Willow? If not, please explain how their responsibilities were allocated.

9. Audit Follow-up
We understood from discussion at the Hearing that there are two 'standard' letters which the RNs send (as needed) as follow-up to the audits, a Letter of Ommission and ??? Please forward a copy of both letters.

10. Cindy's correct title
We noticed that Cindy is referred to as 'Director of Clinical Services' in some places and 'Director of Care' in others. Please confirm her correct title.

11. RN Salary
Are the RN Supervisors paid premium rate for their supervisory role?
Are the 8-hr RNs paid at a different rate than the 12-hr RNs?

12. Staff Numbers in Clinical Services Department
Please provide the total number of staff reporting to Cindy in the Clinical Services Department. Please provide by category (RN, RPN, PSW, Unit Assistant, Scheduling Coordinators, Restorative Therapists and Physiotherapists) and within each category, by full-time, part-time and casual. (I.e. we know for RNs there are 8 FT, 4 PT (2 current vacant positions) and 0 casual -- please provide a similar breakdown for the other staff).

Please provide the above information by email by Wednesday March 17th, using "reply all". I apologize for the short turn-around request, but in order to meet our revised April 1st deadline, our timelines are quite tight.

Thanks very much

Joan

Ontario Nurses' Association Recommendations *Appendix 7*

Recruitment and Retention

Retention and recruitment problems leading to high staff turnover rates and chronic part-time RN vacancies.

1. Develop an ongoing comprehensive retention and recruitment plan by May 01, 2010. ONA members will be consulted and be given the opportunity to provide input. The plan to be discussed at the May 2010 Union Management meeting.
2. Immediately post all RN vacancies on the free Ministry website: Health Force Ontario – https://hfojobs.ca
3. Orientation for all new regulated nursing staff shall include the RNAO *Orientation Program for Nurses in Long Term Care* workbook.
4. Recruit for the four part-time RN vacancies prior to June 01, 2010.

Staffing and Scheduling

Inadequate organization wide base staffing, inefficient scheduling practices, frequently working short staffed related to unfilled shifts on the schedule, inadequate relief staffing to replace sick calls and other absences and frequent requests to the RNs to work overtime.

5. Staffing quotas and resident assignments shall ensure that enough time is available for resident care; and organizational, supervisory and administrative duties.
6. Staffing quotas shall ensure that enough time is available for RNs to properly coach, collaborate, consult with and provide direction to other regulated and unregulated staff.
7. Non-nursing duties shall be identified and discontinued so RNs can make resident care and nursing standards the priority.
8. Ensure that relief staff are consistently available such that the baseline nursing staff (regulated and unregulated) complement shall be maintained 24 hours a day, seven days a week.
9. Develop an improved staffing/contingency plan to be put in place when the activity and/or acuity exceeds the numbers of RNs and other regulated and unregulated staff available to provide care.
10. Monday to Friday RN schedules to revert to 3 RNs 07-19, 1 RN 19-07, 1 RN 07-15 and add 1 RN to the schedule 15-23.

Audits / Performance Appraisals

High volume of audits and required documentation related to MOHLTC unmet standards and areas of non-compliance; and the additional responsibility of performing probationary and annual performance appraisals of RPNs and PSWs; as well as documentation required when RNs provide teaching, coaching or counseling to RPNs and PSWs.

11. RN staffing levels shall ensure the time and resources required to improve resident care.
12. RPNs and PSWs be provided with a tracking tool so they can track all teaching and coaching sessions and apply them to their learning plans.
13. The responsibility for conducting performance appraisals to be returned to the nursing administrative staff. ONA members may be consulted and requested to provide input.
14. All audits shall be evaluated for purpose, value and effectiveness. ONA members will be consulted and given the opportunity to provide input.

Care Delivery Processes

Increased RN workload and care delivery process issues that have resulted in incidences of delayed, improper and/or unsafe nursing care.

15. Revise policies, procedures and practices to be in line with CNO Standards and RNAO Best Practice Guidelines, and that front-line RN staff be consulted and provided an opportunity for input and participation.
16. RN Shift Routines shall be revised and updated. ONA members shall be consulted and provided with an opportunity to provide input.
17. Management shall rotate being on-call and be responsible for call in replacement staff when the schedulers are not on duty. In the alternative, the employer shall extend the hours of the schedulers so that there will be scheduler coverage from 0600 – 2200 hours Monday to Friday. On statutory holidays and weekends, there will be scheduler coverage from 1200 – 2000 hours.

Relationship and Partnership

Relationship and partnership issues between management and RNs that have resulted in communication problems and a perceived lack of professional respect for the Registered Nurses and the nursing profession.

18. Effective, consistent and comprehensive mechanisms for on-going communication shall be established that promote respect and dignity.
19. Staffing quotas shall ensure time for RNs to plan and coordinate multidisciplinary care, properly prepare for and lead multidisciplinary reviews, care conferences and resident assessments.
20. Front-line RNs to be included on all nursing related committees (i.e. education committee, pharmacy committee etc.).
21. The ONA Bargaining Unit President shall be invited to attend, as an observer, the exit meetings with the MOHLTC Compliance Advisor to hear the report. Further, front-line RNs shall be consulted in the development of any plans to improve resident care arising from such Compliance Reports.
22. The ONA Bargaining Unit President shall be invited to attend any accreditation report meetings.
23. Terms of Reference will be jointly agreed to for the Union-Management Committee by May 01, 2010; including a process for agendas, minute taking and minute distribution to be jointly developed and adhered to.
24. That a schedule for Union-Management meetings be jointly developed, agreed to and abided by. That the parties meet monthly for the first year following the receipt of the IAC report and then mutually agree on the frequency of meetings.
25. That a Professional Responsibility Workload Report Form process be jointly developed and adhered to.
26. That management, with the involvement of front-line RNs, implement the following RNAO Healthy Work Environment Guidelines:
    - Preventing and Managing Violence in the Workplace
    - Embracing Cultural Diversity in Health Care
    - Workplace Health, Safety and Well-being of the Nurse
    - Developing and Sustaining Effective Staffing and Workload Practices
    - Collaborative Practice Among Nursing Teams
    - Professionalism in Nursing
    - Developing and Sustaining Nursing Leadership

Organizational Support and Professional Development

Lack of organizational supports, and professional development systems for proper resident care and workload.

27. That management ensures there is a Nurse Administrator on call during off hours.
28. That RN staffing quotas assure enough time for the teaching, coaching and collaboration required to assist the RPNs with the evolution to full scope of practice.
29. That the following RNAO Clinical Best Practices be implemented:
    - Adult Asthma Care Guidelines
    - Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour
    - Assessment and Management of Stage I to IV Pressure Ulcers
    - Assessment and Management of Foot Ulcers for People with Diabetes
    - Assessment and Management of Pain
    - Assessment and Management of Venous Leg Ulcers
    - Best Practice Guidelines for the Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes
    - Caregiving Strategies for Older Adults with Delirium, Dementia and Depression
    - Client Centred Care
    - Crisis Intervention
    - Decision Support for Adults Living with Chronic Kidney Disease
    - Establishing Therapeutic Relationships
    - Nursing Care of Dyspnea: the 6th Vital Sign in Individuals with Chronic Obstructive Pulmonary Disease
    - Nursing Management of Hypertension
    - Oral Care: Nursing Assessment and Interventions
    - Ostomy Care and Management
    - Prevention of Constipation in the Older Adult Population
    - Prevention of Falls and Fall Injuries in the Older Adult
    - Promoting Continence using Prompted Voiding
    - Reducing Foot Complications for People with Diabetes
    - Risk Assessment and Prevention of Pressure Ulcers
    - Screening for Delirium, Dementia and Depression in Older Adults
    - Stroke Assessment Across the Continuum of Care
    - Supporting and Strengthening Families Through Expected and Unexpected Life Events

Appendix 8

Presentation by Christine Byrnes

ACCOUNTABILITY, RESPONSIBILITY, LEADERSHIP & ETHICS
- What Resident is at Risk?

I ASKED MYSELF….. "What resident is at risk? Name one!"
The resident who is at risk is likening to the Unknown Soldier…..
the victim yet undisclosed…

It is NOT the residents listed on the Professional Responsibility Workload Report Form … the resident who fell / or one of the three Palliative residents with or without family at the bedside. It is not, the resident who passed away peacefully while pain free. It is not, the resident whose family member with care concerns needed to speak to me immediately (while I was with the resident who fell assessing them for injury). It is not the resident that the RPN told me is complaining about a physical symptom; or the resident, who just had an altercation with another resident in the secure unit. It is not, the resident who needed the physician called because as an RN, I suspected a urinary tract infection; or the resident, who had suspicious abdominal pain and required the physician consulted and the arrangements for transportation to hospital…where they were admitted.

No….it is none of those named residents in situations that required the expertise of a Registered Nurse. Exercising my rights under the Collective Agreement I advised management by submitting a PRWRF of the risk issues of the workload encountered.

Who is it? It is the resident ….the unknown person…that because of assigned other workload responsibilities, that the RN could not make sure that they were safely transferred to bed so they didn't wake up with a suspicious bruise on their body that the Power of Attorney discovered…especially after they had been confused and agitated. It is more likely to be the resident who complained of a headache; and the only observation I received was a written note after the fact on the daily Unit Report that they required Tylenol; thus no assessment by the RN to check he/she for further symptoms of a progressing stroke….
It is the resident who mentions to the PSW staff that she has pain (but she often complains of this "all the time")…so the complaint never is reported to the RN.
It is the resident unknown to the RN that requires a complete chest assessment for respiratory problems …. but the RN was unaware of this until they had pneumonia….
It will be the unknown resident who has escalating behaviours, confused with a recent urinary tract infection, and is in need of the RN to determine if a delirium is presenting.
It could be the resident who the staff suspected of a fall but never reported it because the resident couldn't be sure themselves due to dementia, thus there was little concern by the staff member until the next shift noticed strange changes of lethargy….no head injury routine was initiated.

These are the nameless residents at risk….the unknown person(s) that are a mere reflection or suggestion in the PRC process….through the same process I am trying to state that on this shift… "I may have missed something while dealing with all of this that I have documented on the PRC form."

Is this not obvious that if all of this was occurring on a particular shift, what is in place to ensure that residents were not at risk?

That is what keeps me up at night, and that is why I must fill out Professional Responsibility Workload Report Forms.

Respectfully submitted

Christine Byrnes
Registered Nurse

Draft Clinical Resource Nurse Role Description

Draft Role Responsibilities:

- Researching, facilitating and promoting best-practice initiatives for Nursing;
- Collaborating and supporting RN Supervisors in areas of research and program planning;
- Creating and monitoring progress of quality initiatives with the ADOC Clinical Standards and ADOC Infection Control and Documentation;
- Assisting nursing staff to understand and model professional practice standards from CNO and the MOHLTC;
- Assisting in the orientation of new staff and their ongoing coached/mentored development;
- Assisting with Policy and Process review and integration of best practices;
- Assisting to develop critical thinking and decision-making of all nursing staff;
- Data collection and planning of practice standards demonstration according to MOHLTC standards for LTC;
- Supporting resident choice and promoting a resident centred approach to care.

Draft Qualifications:

- Current certification with CNO;
- BScN completed or in progress;
- 3-5 years of recent, related currency in gerontological nursing practice;
- demonstrated
  - proficiency in the mentoring and development of staff;
  - ability to provide leadership by involvement with strategic initiatives;
  - ability to role model;
  - recent clinical teaching skills and adult education principles
  - ability to work independently and as a team member
  - ability to deal with and promote change
  - ability to communicate effectively both verbal and written;
- ability to plan, organize and prioritize work;
- demonstrated ability to present materials to groups
- demonstrated ability to evaluate outcomes
- ability to apply research to clinical practice
- demonstrated professionalism, and knowledge of nursing standards as outlined by CNO, professional organization standards, and related legislative requirements;
- strong computer skills (Microsoft Office);
- demonstrated ability to respond appropriately to a crisis situation in a leadership capacity.

COMFORT, REST, AND SLEEP AUDIT

Appendix 10

DATE: ___________________________ **SIGNATURE OF AUDITOR:** _______________

RESIDENTS AUDITED: ____

Audit 3 residents' from various areas of the home during nighttime or rest time in the day

STANDARDS/POLICIES	YES	NO	PT	NA	ACTION TAKEN IF "NO" or "PARTIAL"
ROOM IS CONDUCIVE TO SLEEP/REST					
Noise is controlled					
Lights are controlled					
Night light is on if desired					
Room is well ventilated and free from odours					
Room is free from drafts					
Resident is appropriately dressed for sleeping in own nightwear unless otherwise indicated.					
Call bell is within reach					
Alternatives to sedatives have been used first (refer to documentation)					
RESIDENT IS in LYING POSITION:					
Good body alignment as per Kozier and Erb (Techniques in Clinical nursing)					
Positioning devices in use according to care plan					
Immobile residents' position is changed according to assessed need on Care Plan					
Use of bedrails matches assessed need on Care Plan					
REQUIREMENTS FOR SEATING:					
Have been assessed and documented					
Have been implemented if needed					
OTHER:					
Any documented issues relating to positioning and bedrail entrapment during the current quarter? If yes- Care plan must be reviewed and revised to reflect a new intervention(s) and communicated to staff in the daily unit planner for 3 consecutive days.					

FOLLOW-UP ACTION:

□ Copy/copies given to __________________ for follow up action on (date) __________________
- o Alert Manager/Administrator if any concerns, especially related to safety, need to be resolved immediately
- o If maintenance work required- Maintenance Requisition must be completed (can attach copy of audit if wish to), label the item with a yellow caution tag if unsafe.

□ Follow- up action taken by person responsible:

____

____

____

Manager signature: ____

□ Person responsible gives completed audit to Administrator

□ Administrator reviews and files in Audit binder **Administrator signature:** _________________

Original date of audit: Oct 2001 *Revision date: May 06*

CONTINENCE CARE AUDIT

Appendix 10

DATE: ____________________________ **SIGNATURE OF AUDITOR:** ______________________

STANDARDS/POLICIES	YES	NO	PT	NA	ACTION TAKEN IF "NO" or "PARTIAL"
New admission assessment form is complete					
3 day voiding record has been initiated and/or completed after assessment form has been completed					
Unit planner being utilized- day 1, 2 and 3 of voiding record					
Unit planner being used for day 4 to cue registered staff to look at voiding record for patterns					
7 day bowel record initiated and/or completed after initial assessment form has been completed					
Unit planner being utilized for day 1-7 for bowel record					
Unit planner being used for day 8 to cue registered staff to look at bowel record and plan care accordingly					
If prompted voiding initiated, following section completed:					
• Unit planner being used to designate 3 – 8 weeks for prompted voiding					
• Staff monitoring, cueing and praising residents in regards to prompted voiding					
• 3 day voiding record initiated during prompted voiding					
• unit planner being utilized for the 3 day voiding record					
Care plan, tick sheet and quarterly reflect changes to continence level/ routine					
Staff is using appropriate product for containment as indicated on the care plan, tick sheet and quarterly					

FOLLOW-UP ACTION:

□ Copy/copies given to __________________for follow up action on (date) _____________________

- Alert Manager/Administrator if any concerns, especially related to safety, need to be resolved immediately
- If maintenance work required- Maintenance Requisition must be completed (can attach copy of audit if wish to), label the item with a yellow caution tag if unsafe.

□ Follow- up action taken by person responsible:

____

____

____

Manager signature*:* ____

□ Person responsible gives completed audit to Administrator

□ Administrator reviews and files in Audit binder **Administrator signature:** _________________

Original date of audit: October 2001 *Revision date: May 06*