Independent Assessment Committee Report

Constituted under Article 8.01 of the Collective Agreement

Between

Grand River Hospital, Kitchener

And

The Ontario Nurses’ Association

May 25, 2007
Independent Assessment Committee

Grand River Hospital, Kitchener
and
Ontario Nurses’ Association

May 25, 2007

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The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations concerning the professional workload complaint presented by registered nurses working on the inpatient surgical units (6 North and 6 South) of the Grand River Hospital.

The complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement between the Grand River Hospital and the Ontario Nurses’ Association.

The members of the Independent Assessment Committee extend our appreciation to representatives of the Hospital and the Association, as well as to the registered nurses of the inpatient surgical units, in the presentation of information and response to our questions. We have submitted a number of Recommendations, which we believe will assist all parties to continue to work together, in good faith, to provide optimal care to surgical patients at the Grand River Hospital.

Respectfully submitted

Joan Edwards Cardiff, RN MScN
Chairperson

Beatrice Mudge, RN MBA

Trudy Molke, RN, BScN

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PART I: INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee ("the IAC") report is presented in five parts:

- Part I outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC's jurisdiction as outlined in the Collective Agreement, and presents the Pre-Hearing, Hearing and Post-Hearing processes.

- Part II reviews the context of practice relating to the professional workload complaint, the history leading to the referral of the professional workload complaint to the IAC, and the presentations by the Ontario Nurses’ Association ("the Association") and the Grand River Hospital ("the Hospital") at the Hearing.

- Part III presents the IAC's analysis and recommendations

- Part IV presents the conclusion and provides a summary of the recommendations

- Part V contains Appendices referenced in the Report.

Supporting data, including the submissions and exhibits of both parties, are on file with the Ontario Nurses’ Association.

1.2 Referral to the Independent Assessment Committee

This report addresses the professional workload complaints of the Registered Nurses on the two Inpatient Surgical Units, 6 North and 6 South, at the K-W Health Centre site of the Grand River Hospital in Kitchener, Ontario.

The Hospital and Local 139 of the Association have worked together to address professional workload issues relating to the Inpatient Surgical Units since 2004. Professional workload issues/concerns/complaints have been discussed on a regular basis at Hospital Association Committee (HAC) meetings. In recognition of the concerns relating to the Inpatient Surgical Units, a Core Group was initiated in January 2006 to focus specifically on the issues on these Units. The Core Group met seven times between January and June 2006. However, despite significant time and effort on all parts, the Registered Nurses did not believe that the outstanding issues would/could be satisfactorily resolved through this mechanism. Accordingly, the Association formally referred unresolved concerns to the Article 8.01 process on October 26, 2006.

An IAC was struck, with nominees from the Hospital and the Association, and a Chairperson drawn from the list of Chairpersons contained in Appendix 2 of the Central Collective Agreement. When the Chair had to withdraw from the process for personal reasons, the IAC was reconstituted in early February 2007 with a new Chairperson. The Association formally reiterated the unresolved concerns in a letter to the reconstituted IAC on March 20, 2007 (Appendix I).
1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Collective Agreement between the Ontario Hospital Association / Grand River Hospital and the Ontario Nurses’ Association. Article 8.01 states:

The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner.

In the event that the Hospital assigns a number of patients or a workload to an individual nurse or group of nurses such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care, they shall....

The creation of an IAC is referenced in Article 8.01 (a) vi) and Article 8.01 (a) vii)

8.01 (a) vi)
Failing resolution of the complaint within fifteen (15) calendar days of the meeting of the Association-Hospital Committee the complaint shall be forwarded to an independent Assessment Committee composed of three (3) registered nurses; one chosen by the Ontario Nurses’ Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair.

8.01 (a) vii)
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 make what findings as are appropriate in the circumstances. The Assessment Committee shall report its findings, in writing, to the parties within thirty (30) calendar days following completion of its hearing.

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 patient care. Workload is influenced by both direct factors (e.g. nurse:patient ratio, patient acuity) and indirect factors (e.g. processes and systems of care). Concerns outside of workload are beyond the jurisdiction of the IAC. The IAC’s responsibilities cease with the submission of its written report to the parties. The IAC’s findings and recommendations are intended to provide an external independent perspective to assist the parties to achieve a mutually agreed resolution, and are not binding.

In accordance with Professional Responsibility Article 8.01 (a) (vi) of the Collective Agreement, the IAC was comprised of three Registered Nurses. The members of the IAC were:

For the Association:
- Trudy Molke
  - Health Care Consultant

For the Hospital:
- Beatrice Mudge
  - Vice President Patient Services / Chief Nursing Executive, Cambridge Memorial Hospital

Chairperson:
- Joan (Edwards) Cardiff

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1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

The reconstituted IAC held its first meeting by teleconference on February 7, 2007. The IAC discussed logistics associated with the Hearing, reviewed a draft Agenda for the Hearing, and discussed submission and distribution of Pre-Hearing Briefs. Following the teleconference, the IAC Nominees discussed potential dates with their respective parties. The IAC, the Hospital and the Association agreed on February 15, 2007 that the Hearing would be held on April 17 – 19, 2007 at the Delta Kitchener Hotel.

In order to support the principles 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 the Hospital and the Association to submit all relevant documentation to the IAC by March 23, 2007. The IAC wrote to the Hospital and the Association on February 19, 2007, confirming the Hearing Agenda and addressing the issue of pre-hearing disclosure of information and submission of Pre-Hearing Briefs (Appendix II).

The IAC Chairperson received the Hospital and Association Pre-Hearing Briefs as requested on March 23, 2007, and distributed the Pre-Hearing Briefs by courier to all parties on March 26, 2007. The IAC requested that any additional information be submitted by April 2, 2007 (Appendix III). Both the Hospital and the Association submitted additional information by this date (Appendix IV).

The IAC met face-to-face on April 4, 2007, to discuss the Pre-Hearing Briefs and additional information submitted by the Hospital and the Association, determine if any further information was required in advance of the Hearing, and identify key issues for exploration at the Hearing. Following this meeting, the IAC requested the Hospital to provide specific additional information at the initiation of the Hearing (Appendix V).

The IAC met prior to the Hearing on the morning of April 17, 2007, to review the anticipated timing/process of the Hearing.

The IAC toured the Inpatient Surgical Units, 6 North and 6 South, at the K-W Health Center Site of the Grand River Hospital from 10:00 – 12:15 hours on the morning of April 17, 2007. The Site Tour was conducted by the following representatives:

On behalf of the Hospital: Brenda Leis, Clinical Director, Inpatient Surgical Program
Gloria Whitson-Shea, Vice President and Chief Nursing Officer

On behalf of the Association: Anne Good, Registered Nurse, 6 North, 6 South, and Pain Program
Janet Hintermayer, Registered Nurse, 6 North
Mariana Markovic, Professional Practice Specialist, ONA
Edie McMyler, Registered Nurse, 6 North
Elaine Reed, Bargaining Unit President, Local 139
Kathi Wilkins-Snell, Servicing Labour Relations Officer, ONA
Shannon Wright, Registered Nurse, 6 South
1.4.2 Hearing

The Hearing convened at 1300 hours on April 17, 2007. The Hearing was held in the Kitchener IV Ballroom at the Delta Kitchener Hotel. The Hearing schedule (Appendix VI) was as follows:

- April 17, 2007: 1300 – 1730 hours
- April 18, 2007: 0900 – 1715 hours
- April 19, 2007: 0830 – 1300 hours

Participants and Observers at the Hearing are listed in Appendix VII.

The format of the Hearing was as follows:

April 17, 2007:

- The IAC Chairperson opened the proceedings at 1300 hours. She reviewed the jurisdictional scope of the IAC, including the purpose of the IAC Hearing and the processes agreed to by both the Hospital and the Association as outlined in the Collective Agreement. She reviewed the ‘ground rules’ for the hearing Procedures. The IAC members, and the Hearing Participants and Observers introduced themselves, and indicated that they agreed with the ‘ground rules’.

- Mariana Markovic, Professional Practice Specialist, ONA and Anne Good, Janet Hintermayer, Jorja Lamb, Edie McMyler, and Shannon Wright, Registered Nurses on the Inpatient Surgical Units, presented the submission on behalf of the Association, and responded to questions of clarification from the Hospital and the IAC.

- Patrick Gaskin, Acting President and Chief Executive Officer of the Hospital provided introductory comments. Rusty McLay, Counsel for the Grand River Hospital, presented the submission on behalf of the Hospital, and responded to questions of clarification from the Association and the IAC.

April 18, 2007:

- The IAC Chairperson opened the proceedings. She reviewed the ‘ground rules’ for the Hearing process, and ensured that all new Hearing Observers were introduced.

- Rusty McLay, Counsel for the Grand River Hospital, and Brenda Leis, Clinical Director for the Inpatient Surgical Program and Gloria Whitson-Shea, Vice President Nursing, responded to the Association submission.

- Mariana Markovic, Professional Practice Specialist, ONA, Rozanna Haynes, Professional Practice Specialist, ONA, and Janet Hintermayer, Jorja Lamb, Edie McMyler, and Shannon Wright, Registered Nurses on the Inpatient Surgical Units, and Elaine Reed, Local 139 Bargaining Unit President, responded to the Hospital Submission.

Following the presentation of the Hearing Submissions and Responses from both the Hospital and the Association, the IAC met during the evening of April 18, 2007 to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion.
April 19, 2007:

• The IAC Chairperson opened the proceedings.

• The IAC reviewed the issues requiring further clarification and discussion with the parties in a Question and Answer session, during which all Hearing Participants actively participated.

• The Chairperson closed the proceedings at 1300 hours. She thanked all participants for their commitment to the Hearing, and for their open discussion during the Hearing. She noted the IAC’s appreciation for the active involvement of the large number of Registered Nurses and the Acting President and Chief Executive Officer who attended the Hearing. She reaffirmed that the IAC’s Report and associated recommendations are not binding but rather are intended to provide the Association and the Hospital with an external independent perspective to aid in the resolution of outstanding issues. She confirmed that the IAC’s Report would be distributed on May 25, 2007.

1.4.3 Post Hearing

The IAC met briefly immediately following the Hearing to begin to consider the findings from the on-site visit (Tour), discuss the Submission and Response information, and formulate conclusions and recommendations.

The IAC reviewed the first draft of the Report independently, and met for a face-to-face meeting on May 7, 2007 to review the second draft and discuss the findings and recommendations in depth. The IAC met by teleconference on May 18, 2007 and May 23, 2007 to finalize the Report.

The Final Report was submitted to the Hospital and the Association by courier on Friday May 25, 2007.
PART II: PRESENTATION OF THE PROFESSIONAL WORKLOAD COMPLAINT

2.1 Context of Practice

2.1.1 Structure of the Surgical Services Program

The surgical services at the Grand River Hospital were consolidated onto the 6th floor of the K-W Health Centre site of the Hospital in 1998. As part of regional rationalization, the surgical services from St Mary’s General Hospital were amalgamated in 2004. The Inpatient Surgical Program includes orthopedics, general surgery and gynecology services. Patients are admitted from the Emergency Department, the Operating Room/Post Anaesthetic Care Unit (PACU), the Intensive Care Unit (ICU), medical units within the Hospital, other hospitals, and from home. The 72 beds within the Program admit approximately 472 patients per month, and report an average 93% occupancy.

Following the rationalization of surgical services between the Grand River and St Mary’s Hospitals in 2004, the Grand River Hospital became the trauma and orthopedic centre for the Kitchener-Waterloo area, and as such provides surgical coverage on a 24/7 basis. Patients who require tertiary or quaternary level care (e.g. those who require neurosurgical support) are transferred to the academic health science centres in Hamilton or London.

The Clinical Director of the Inpatient Surgical Program reports to the Vice President Surgical Services, who in turn reports to the President and Chief Executive Officer. The Vice President Nursing (who holds a line portfolio in other clinical areas of the Hospital) provides professional nursing practice leadership for all nurses, including those on the 6th floor.

2.1.2 Configuration of the Inpatient Surgery Units

The Inpatient Surgery Units are located on the top floor of the North/South wing of the Hospital. The wing was constructed about 50 years ago, and is approximately 36,000 sq ft in size.

The south end of the 6th floor (6 South) has 30 beds and is focused on Orthopedics. 6 South is configured in a U-shape, with the nursing station, clean and dirty utility rooms, patient bathrooms, housekeeping supply etc located on the inside corridor and patient rooms (4 ward, 5 semi-private and 4 private rooms) on the outside. The private rooms are used for isolation as required. The Unit has two linen carts (one on each side of the “U”), three medication carts (one per nursing team), one Accudose machine (located in the clean utility room), and a number of computer terminals located at the nursing station and at desks in the hall. Although efforts have been made to keep the hallways clear of equipment, the unit appeared crowded and the clean supply room appeared very cluttered at the time of the Site Tour.

The north end of the 6th floor (6 North) has 42 beds. Thirty-six (36) of the beds are focused on general surgery and gynecology; 6 beds comprise an Observation Unit (OBS Unit) that functions as a surgical step-down unit. As with 6 South, the nursing station, clean and dirty utility rooms, patient bathrooms, storage rooms etc are located on the interior of the “U” shape, and the patient rooms (4 wards, 6 semi-privates and 4 privates1) are located on the outside. Ten (10) of the 36 beds are located in a semi-isolated section between the OBS Unit and 6 South. 6 North has three

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1 When the OBS Unit closes, the number of ward rooms will increase from 4 to 5.

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linen carts (two on each side of the main “U” and a third in the 10-bed section), a medication cart for each nursing team on the floor and one in the Observation Unit, one Accudose machine in the clean utility room, and computer terminals located at the nursing station and at desks throughout the unit. 6 North also appeared crowded, and the supply room disorganized at the time of the Site Tour.

The 6-bed OBS Unit includes a small nursing station, a separate medication cart, and a small utility room. The OBS Unit functions as a surgical step-down, caring for patients who are not ventilated but who require complex assessment, complex and/or time-intensive therapeutic interventions, pain management, or observation. The OBS Unit is connected by telemetry to the CCU; there is a 2-lead monitor screen in the OBS Unit, but the nurses depend on the CCU nurses to alert them of ECG changes. Decision to admit to the OBS Unit is determined by the MRP surgeon; however, nurses also have the autonomy to transfer patients into the OBS Unit for enhanced assessment or nursing care if they believe this is required.

2.1.3 Inpatient Surgical Program Staffing

At the time of the Hearing, the Inpatient Surgical Program had 40 full-time and 18 regular part-time Registered Nurses and 17 full-time and 24 part-time Registered Practical Nurses.

- Of the 40 full-time RNs,
  - Eighteen (18) (14 plus the 4 Resource Nurses) were considered “senior”,
  - seven (7) were “intermediate”,
  - nine (9) were “junior”, and
  - two (2) were new graduates.

- Of the 18 regular part-time RNs,
  - Eleven (11) were considered “senior”,
  - one (1) was “intermediate”, and
  - six (6) were “junior”.

As indicated by the proportions of “senior” and “junior” staff, there has been a significant turnover of staff over the past two years. Although as of March 21, 2007, the Inpatient Surgical Program had only four (4) vacant positions (three (3) RN, one (1) RPN), there are a large number of Maternity Leaves upcoming within the next six (6) months.

2.1.3.1 6 North / 6 South Staff Schedule

The current staffing for 6 South and 6 North is indicated in Table 1. Table 1 does not include other professional staff assigned either temporarily or permanently to the Inpatient Surgical Program (e.g. Physiotherapist, Pharmacist) or support staff (e.g. Porter).

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2 This determination, provided on request of the IAC, was mutually determined by the Clinical Director and one of the Resource Nurses. “Senior” is not related to ‘seniority’ as per the Collective Agreement, but rather to expert practice. “Junior” relates to a novice nurse.
<table>
<thead>
<tr>
<th></th>
<th>6 North</th>
<th>6 South</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RN/RPN</strong></td>
<td>Ward (36 beds)</td>
<td>Ward (30 beds)</td>
</tr>
<tr>
<td><strong>Days: Monday – Saturday</strong></td>
<td><strong>0700 – 1900</strong></td>
<td><strong>0700 – 1500</strong></td>
</tr>
<tr>
<td></td>
<td>1 Resource Nurse</td>
<td>1 Resource Nurse</td>
</tr>
<tr>
<td></td>
<td>4 RNs</td>
<td>3 RNs</td>
</tr>
<tr>
<td></td>
<td>3 RPNs</td>
<td>2 RNs</td>
</tr>
<tr>
<td><strong>Sunday</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0700 – 1500</td>
<td>1 Resource Nurse</td>
</tr>
<tr>
<td></td>
<td>4 RNs</td>
<td>3 RNs</td>
</tr>
<tr>
<td></td>
<td>3 RPNs</td>
<td>3 RPNs</td>
</tr>
<tr>
<td></td>
<td>1500 – 1900</td>
<td>2 RNs</td>
</tr>
<tr>
<td></td>
<td>3 RPNs</td>
<td>3 RPNs</td>
</tr>
<tr>
<td><strong>Nights: Monday – Sunday</strong></td>
<td><strong>1900 - 0700</strong></td>
<td><strong>0700 – 1900</strong></td>
</tr>
<tr>
<td></td>
<td>4 RNs</td>
<td>3 RNs</td>
</tr>
<tr>
<td></td>
<td>3 RPNs</td>
<td>3 RPNs</td>
</tr>
<tr>
<td><strong>Ward Clerk</strong></td>
<td>Ward plus OBS Unit (42 beds)</td>
<td>Ward (30 beds)</td>
</tr>
<tr>
<td><strong>Days: Monday – Friday</strong></td>
<td><strong>0700 – 1500</strong></td>
<td><strong>0900 – 1700</strong></td>
</tr>
<tr>
<td></td>
<td>1 WC</td>
<td>1 WC</td>
</tr>
<tr>
<td></td>
<td>1 WC</td>
<td>1 WC</td>
</tr>
<tr>
<td><strong>Saturday – Sunday</strong></td>
<td><strong>0700 – 1900</strong></td>
<td><strong>1500 – 2300</strong></td>
</tr>
<tr>
<td></td>
<td>1 WC</td>
<td>1 WC</td>
</tr>
<tr>
<td><strong>Nights: Monday – Friday</strong></td>
<td><strong>1500 – 2300</strong></td>
<td><strong>1900 - 0700</strong></td>
</tr>
<tr>
<td></td>
<td>1 WC</td>
<td>1 WC</td>
</tr>
<tr>
<td><strong>Clinical Assistant</strong></td>
<td>Ward plus OBS Unit (42 beds)</td>
<td>Ward (30 beds)</td>
</tr>
<tr>
<td><strong>Days: Monday – Sunday</strong></td>
<td><strong>0700 - 1500</strong></td>
<td><strong>1500 – 2300</strong></td>
</tr>
<tr>
<td></td>
<td>1 CA (shared with 6 South)</td>
<td>1 CA (shared with 6 South)</td>
</tr>
<tr>
<td><strong>Housekeeper</strong></td>
<td>Ward plus OBS Unit (42 beds)</td>
<td>Ward (30 beds)</td>
</tr>
<tr>
<td><strong>Days: Monday – Sunday</strong></td>
<td><strong>0700 – 1500</strong></td>
<td><strong>1200 – 1600</strong></td>
</tr>
<tr>
<td></td>
<td>1 HK</td>
<td>1 HK</td>
</tr>
<tr>
<td></td>
<td>1 HK</td>
<td>1 HK (shared with 6 South)</td>
</tr>
<tr>
<td></td>
<td>1 HK (shared with 6 North)</td>
<td>1 HK (shared with 6 North)</td>
</tr>
</tbody>
</table>
In any given 24 hour period, there are a total of 30 direct care nursing shifts (9 RNs and 6 RPNs on each of the Day and Night shifts) scheduled between 6 North and 6 South. As indicated in Table 2, during the period January 1, 2007 to March 31, 2007, full nursing staffing (i.e. 30 nurses - RNs/RPNs) occurred 86% of the time, while short-staffing (29 nurses or less) occurred 14%.

Table 2

<table>
<thead>
<tr>
<th># of RNs and RPNs / 24 hour period</th>
<th># Days / 90 days January 1 – March 31, 2007</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>1</td>
<td>1.1 %</td>
</tr>
<tr>
<td>29</td>
<td>12</td>
<td>13.3 %</td>
</tr>
<tr>
<td>30</td>
<td>53</td>
<td>58.8 %</td>
</tr>
<tr>
<td>31</td>
<td>14</td>
<td>15.5 %</td>
</tr>
<tr>
<td>32</td>
<td>6</td>
<td>6.7 %</td>
</tr>
<tr>
<td>33</td>
<td>2</td>
<td>2.2 %</td>
</tr>
<tr>
<td>34</td>
<td>2</td>
<td>2.2 %</td>
</tr>
</tbody>
</table>

2.1.3.2 Nursing Leadership

The Inpatient Surgical Program is led/managed by the Clinical Director, who is also responsible for the Pain Service, IV Team, Fracture Clinic, Medical Day Unit and Ambulatory Registration. Her office is located on 6 North.

The Clinical Director position changed in October 2006. The appointment of the new Clinical Director, an RN with 19 years experience at the Hospital including three (3) years in a leadership position, was viewed very positively.

The Educator/Practice Lead covers the 6th floor as well as the Ambulatory Care Clinics and the IV team. Her office is also located on 6 North.

2.1.3.3 Resource Nurse Role

Each Unit has a dedicated Resource Nurse position. Since September 2006, the Resource Nurses have worked 0700 – 1900 Monday to Saturday and 0700 – 1500 Sunday. The four Registered Nurses who cover these positions (two work on 6 North, two work on 6 South) work a rotating two-days-on / two-days-off schedule. The Resource Nurse on 6 North also covers the Observation Unit. The Resource Nurses do not carry a patient assignment. They are responsible for day-to-day coordination of all activities on the Unit, including patient admissions, discharge planning and coordination of multi-disciplinary care needs, nurse-patient assignments, problem-

---

1 This very blunt evaluation does not take into consideration the number of shifts which required short notice replacement, the acuity/care needs of the patients, the number of admissions/discharges/transfers in any given day, the RN/RPN staff mix, novice to expert ratio, or the patient census. It only indicates that full staffing existed the vast majority of the time.

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solving patient/family concerns/complaints, and staffing replacement (for Nights and on weekends).

After hours (Long Night Monday to Saturday and Evening / Night Sunday), an RN on each Unit assumes Charge Nurse responsibilities. She/he usually carries at least a partial patient assignment, necessitating the other RN-RPN teams to carry a heavier patient assignment than the regular 1:5 nurse:patient ratio.

Prior to September 2006, the four Resource Nurses worked 7.5 hour shifts covering the hours of 0700 – 2300 Monday to Friday, and did not work on the weekend. The night and weekend Charge Nurse role was covered by an RN with a partial to full patient assignment. The decision to reallocate 3.75 hours per evening Monday to Friday to enable Saturday and Sunday Day shift Resource Nurse coverage was based on the desire for enhanced coordination of Unit activities on the weekend, and the understanding that (a) the Observation Unit would be moving to the 2nd floor and (b) the evening Operating Room schedule would be decreasing by 4 hours (therefore decreasing the number of post-operative patients received on the Units after 1900 hours).

2.1.3.4 Observation Unit

The 6-bed OBS Unit is staffed at a 1:3 nurse:patient ratio 24/7, with two RNs on both Days (11.25 hrs) and Nights (11.25 hrs). The Clinical Director and Resource Nurses endeavour to place senior experienced RNs in the OBS Unit, although this is not always possible. The RNs are considered part of 6 North (and are drawn from the 6 North staff).

The master rotation in place between September 8, 2006 and April 5, 2007 included only one (1) RN per shift for the OBS Unit. Accordingly, for the seven month period that the interim schedule was in place, an additional RN, drawn from the part-time pool, has been scheduled ("backfilled") into the OBS Unit.

The new master rotation (implemented April 6, 2007) also includes only one (1) RN for the OBS Unit. A second ‘backfill’ RN position will continue to be required 24/7 until the OBS Unit moves on May 22, 2007.

2.1.3.5 6 North: General Surgery and Gynecology

The new (April 6, 2007) 6 North master rotation includes 20 lines for Registered Nurses (not including the Resource Nurses). The RNs work a 4-on / 5-off schedule, as identified in Article G-5 of the Local Agreement between the Hospital and the Association. The four (4) consecutive shifts consist of two (2) 11.25 hour Days immediately followed by two (2) 11.25 hour Nights, followed by five (5) consecutive days off. The master rotation has been developed such that there is overlap on all shifts (e.g. some of the RNs working Days Monday worked Days Sunday; the...

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4 The September 2006 master rotation schedule was developed on the understanding that the 6-bed OBS Unit would be relocated to the second (2nd) floor and that 4 beds would remain as general surgery beds (moving 6 North from 36 beds to 40 beds). One (1) RN was to be added to the ‘floor complement’ and the second RN position was to be removed from the schedule (and transferred to the new OBS Unit). The OBS Unit did not move as anticipated; therefore a second “backfill” RN has been required for all shifts as the September Master Rotation included only the one (1) RN position remaining on 6 North.

5 This complement also includes the RNs assigned to the OBS Unit.
other RNs working Days Monday will work Days Tuesday, when the RNs who worked Days Sunday have moved to Nights).  

There are four (4) RNs and three (3) RPNs on each Day Long and Night Long shift. Three (3) of the RNs are buddied with an RPN, and carry a 1:5 nurse:patient assignment (each of the RN and the RPN cares for five (5) patients). The fourth RN (who is not in an RN-RPN team) carries a 1:6 patient assignment. The team assignments are based on room configuration (i.e. Team 1 always has rooms X and Y) rather than patient acuity.

The RN is responsible for all care requirements for her/his five (5) patients, and for the care requirements outside of the RPN's scope for the RPN's five (5) patients. These include procedures such as PICC dressing and tubing changes, administration of IV medications, administration of epimorph and monitoring pain controlled analgesia (PCA) pumps, VAC dressings etc, as well as taking verbal/telephone orders and checking orders.

2.1.3.6 6 South: Orthopedic Surgery

The new (April 6, 2007) 6 South master rotation includes 12 lines for Registered Nurses (not including the Resource Nurses). The RNs also work a 4-on / 5-off schedule as identified in Article G-5 of the Local Agreement.

There are three (3) RNs and three (3) RPNs on each Day Long and Night Long shift. Each of the RN-RPN teams carry a 1:5 nurse:patient assignment (e.g. each of the RN and RPN cares for five (5) patients). As with 6 North, the team assignments are consistent and are based on room configuration.

As with 6 North, the RN is responsible for all care requirements for her/his five (5) patients, and for the care requirements outside of the RPN's scope for the RPN's five (5) patients, including PICC dressing and tubing changes, administration of IV medications, administration of epimorph and monitoring pain controlled analgesia (PCA) pumps, and taking verbal/telephone orders and checking orders. In addition, a tremendous amount of basic care needs (e.g. toileting, ambulating) for the orthopedic patient population requires two nurses.

2.1.3.7 Multidisciplinary and Support Staff

Other regulated professionals supporting 6 North and 6 South include Physiotherapists, Occupational Therapist, Clinical Pharmacist, Dietician and CCAC/Discharge Planners.

- Three (3) Physiotherapists work on the 6th floor, Monday to Friday (days), two focus on 6 South and one covers 6 North. Approximately 72% of the Physiotherapists' workload centres on 6 South, with 28% focused on 6 North. In addition, there are two (2) Physio Assistants on 6 South and one (1) on 6 North. As the Physiotherapy Room is located on 6 South, patients do not require transportation to leave the floor to access physiotherapy. The Physiotherapists work closely with the nurses to coordinate patient care (e.g. Physio will plan for patients to get up at meal-time). Generally the Physiotherapist and Physio Assistant will

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6 The RPN master rotation on both 6 North and 6 South has also been configured to provide overlap with the RN schedule, to enhance continuity within the RN-RPN care team as much as possible.

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get the patients up and complete the physio treatments; returning the patients to bed is usually the nurse’s responsibility.

- One (1) **Occupational Therapist** is dedicated to the 6th floor, spending approximately 80% of time on 6 South and 20% of time on 6 North.

- Each of 6 North and 6 South has a **Clinical Pharmacist** assigned to the Unit Monday to Friday. The Clinical Pharmacists review all medication orders and ensure processing, review home medications, dose medications (physician delegation) and provide drug information resource support to the nurses.

- One (1) **Dietician** covers the 6th floor during the week.

- Two (2) **CCAC/Discharge Planners** cover each of 6 North and 6 South, Monday to Friday. Each CCAC/Discharge Planner is responsible for planning for 15 patients.

Support staff for 6 North and 6 South include a Clinical Assistant, Housekeepers, and Ward Clerks.

- There is one (1) **Clinical Assistant** assigned to cover both 6 North and 6 South seven days per week. This position has traditionally been focused on 6 South, to assist in meeting care needs of the orthopedic patient population (e.g. mobilization). The previous Clinical Assistant has recently retired, and the new incumbent is being actively encouraged to work on both ends of the floor. The Clinical Assistant works 0700 – 1500 Monday to Sunday.

- There are four (4) **Housekeeper** positions assigned to the 6th floor, who work the following hours:
  - 6 North: 0700 – 1500
  - 6 South: 1200 – 1600 (focuses on the semi-isolated 10 bed area)
  - 6 North / 6 South Shared: 0700 – 1500
  - 6 North / 6 South Shared: 1000 – 1800

- After hours, one Housekeeper covers the medical / surgical areas of the Hospital (including the 6th floor, 5th floor and oncology, totaling approximately 165 beds). When late discharges (after 1800 hours) occur, she/he is accessed by pager.

- Each of 6 North and 6 South have **Ward Clerk** coverage on Days and Evenings Monday to Friday, and on Long Days Saturday and Sunday, as per the following schedule:
  - Monday to Friday: 0700 – 1500
  - 0900 – 1700
  - 1500 – 2300
  - Saturday/Sunday: 0700 – 1900

- After hours, any required clerical support is provided by the RNs.

The Hospital has a centralized VIP **Portering** service, which operates 0700 – 2300 Monday to Sunday. The Porter is accessed through a (complicated) telephone access system, which provides a confirmation number for the portering request but does not include a voice-to-voice communication with either the Porter or a dispatcher. The system does enable priority calling for a ‘stat bed’, although the response time can be long, resulting in the need for nurses (and sometimes physicians) to porter patients to the OR. In addition, patients who require
transportation by stretcher can be moved by the Porter alone, but those who are transported in a bed require a second person (usually a nurse) to assist. Porters generally do not participate in transferring patients between rooms within the Unit (e.g. patients moved due to acuity, to create a male/female room etc).

2.1.3.8 Staffing Process

Staffing is managed through several processes.

The Master Rotation is developed and posted in advance, as per the Collective Agreement. Following implementation of the September 2006 Master Rotation, a number of concerns were identified, including a ‘clustering’ of the novice staff on 6 South, the need to more evenly balance the scheduling of part-time RNs between 6 North and 6 South and between the part-time RNs themselves, and the need to provide better continuity across the RN ‘blocks’. The Clinical Director worked with the Unit Council to facilitate implementation of a revised Master Rotation. RNs posted into the new schedule’s full-time lines based on seniority; the nine (9) RNs with the least seniority posted into specific lines to ensure a balancing of expert and novice staff on each team. The new Master Rotation was implemented on April 6, 2007.

Advanced requests for scheduled time off (e.g. family leave, day(s) off, vacation) are made to the Staffing Office. For the past several years, the Staffing Office was centralized, and was located at the Freeport site of the Hospital. Numerous difficulties were identified with this model; as of April 1, 2007 the Staffing Office was decentralized and the Staffing Clerks for each Program are now physically located within or close to the Program area. RNs make requests to the Staffing Clerk, who grants the request if (a) the request is within the quota of number of staff off per day (quota is 3 RNs and 3 RPNs off in a 24 hour period) and (b) replacement staff are available. The Clerks use an electronic scheduling system (ESP Program) that identifies the nurses who are available on the shift in question; the Clerk calls these individuals in order of seniority. If the request cannot be granted, the Clerk refers the request to the Clinical Director, and sends a note to the nurse, who is then generally responsible for trying to coordinate her/his own replacement (generally through switching shifts with a colleague).

Last minute staffing change/request(s) (e.g. sick calls) are addressed in a variety of ways, depending on the time that the request is made.

- Between 0700 – 1500, nurses call their Program Staffing Clerk, who arranges for replacement through placing a request for allocation of a nurse from the Float Pool, or (if the Float Pool has no-one available) by calling available staff on the Unit casual and regular part-time list in order of seniority.
- After hours (1500 – 2300), nurses making last minute requests leave a message on a voicemail.
  - Voicemail messages left between 1500 and 2300 are picked up by the Clinical Administrator (“shift supervisor”). She/he determines whether already scheduled staff can be reassigned within the Hospital, assigns a nurse from the Float Pool, or requests the Resource Nurse to call the available Unit-based casual and regular part-time nurses.
  - Voicemail messages left between 2300 and 0600 are picked up by a Staffing Clerk who comes in at 0600 (the Staffing Clerks rotate this responsibility). She/he either assigns a nurse from the Float Pool, or requests the Unit to call Unit-based replacement staff.
When replacement staff are not available, the most senior nursing administrator (on days: Inpatient Surgery Clinical Director; on evenings: Clinical Administrator; on nights: Administrator on Call) is responsible for determining whether nurses are to be ‘ordered in’ for premium shifts. Although there is no defined clause for mandated ‘ordering in’ in either the Central or Local Collective Agreement, discussion at the Hearing indicated that the process appears to be fairly frequently used, and is perceived by the nurses to have become a method of ‘general regular staffing’. Registered Nurses at the Hearing reported that full-time and regular part-time nurses, who have worked their total scheduled hours but are frequently called for additional shifts, tend not to answer the phone in order to avoid being ‘ordered in’.

2.1.3.9 Float Pool

The Hospital has a Float Pool, which is managed under the office of the Vice President Nursing. There are currently 20 FTE positions within the Float Pool. The RNs and RPNs in the Float Pool indicate a ‘primary’ and ‘secondary’ area of practice, and are assigned, as much as possible, to these areas. In February, 18% of the Float Pool RN hours and 12% of the Float Pool RPN hours were assigned to Inpatient Surgery, a decrease of 8% and 5% respectively from January 2007. The IAC was not clear whether these assigned hours met the needs/requests of 6 North and 6 South, or whether they were all that were available.

Due to the high usage of the Float Pool by Critical Care and Emergency, new positions are being added to create a “Critical Care Float Pool” in this fiscal year. It is hoped that this will free up the current 20 FTE Float Pool complement to be more available to the other areas in the Hospital, such as medicine and surgery.

The Float Pool is intended to provide short-term staffing support. The Float Pool nurses work an assigned schedule; they are not ‘pre-booked’ in advance to a Unit, rather are assigned a Unit work placement when they arrive for the shift. In relation to short-term staffing requirements, it is expected that Float Pool nurses will staff any “flex beds” which are opened as per the new Full Capacity Protocol.

2.1.3.10 Sick Time

The data provided to the IAC indicated that the sick time for Inpatient Surgery for the period January 1, 2007 through March 31, 2007 totaled 1281.25 hours, which, simply calculated, comprises between 4.2% and 7% of total paid hours. The Hospital, in its Pre-Hearing Brief, indicated that sick time accounted for 6.23% of total scheduled time, approximately 6 shifts per nurse per year. The Association provided data at the Hearing relating to sick time on 6 South during March 2007, which indicated that there were 14 sick calls (5 RNs and 9 RPNs) during the

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7 The Full Capacity Protocol is initiated when all stretchers in the Emergency Department are full, no in-patient beds are available and there are 6 admitted patients holding in the ER. The goal is to ensure that the Emergency Department remains functional at all times.

8 January 1, 2007 to March 31, 2007 is 90 days; 30 nurses (RNs and RPNs) per day each working an 11.25 hour shift totals 30,375 hours (30,375 / 1281.25 = 4.2%). 18 RNs per day each working an 11.25 hour shift totals 18,225 hours (18,225 / 1281.25 = 7.0%). These very rough calculations do not include the Resource Nurse position.
month. This means that nurses called in sick 14 out of 372 shifts\(^9\) -- 3.7% of the time, or, stated differently, that in every 24 hour period there was a sick call almost every second day\(^10\).

2.1.3.11 Overtime

The data provided to the IAC indicated that paid overtime decreased 27% between the period January 1, 2006 to March 31, 2006, as compared to the period January 1, 2007 to March 31, 2007. As indicated in Table 3, the gross number of overtime (premium @ 1.5) hours per day during the first three months of 2006 averaged 3.95, while the gross number of overtime (premium @ 1.5) hours per day during the same time period in 2007 averaged 2.50, a difference of 27%. The IAC was unable to determine what proportion of this decrease this was due to an actual decrease in required overtime and what proportion was due to a decrease in reporting of overtime\(^11\).

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Full time</th>
<th>Regular Part Time</th>
<th>Casual</th>
<th>Total</th>
<th>#Hrs per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Total hrs / 90)</td>
</tr>
<tr>
<td>January 1 – March 31, 2006</td>
<td>293.42</td>
<td>57.08</td>
<td>5.75</td>
<td>356.25</td>
<td>3.95</td>
</tr>
<tr>
<td>January 1 – March 31, 2007</td>
<td>179.50</td>
<td>45.25</td>
<td>3.75</td>
<td>228.50</td>
<td>2.50</td>
</tr>
</tbody>
</table>

\(^9\) March 2007 is 31 days; 12 shifts per day (6 RNs and 6 RPNs are scheduled in each 24 hour period) totals 372 total shifts during the month.

\(^10\) 14 sick calls in 31 days means there within each 24-hour period, there was a sick call 45.2% of the time.

\(^11\) At the Hearing, the nurses indicated that overtime was under-reported, that they frequently missed breaks and worked late, but did not report this time.

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2.1.4 Workload Measurement

The Ministry of Health and Long-term Care (MOH-LTC) indicated to all hospitals in early 2006 that maintenance of a nursing workload measurement system was not longer required (and would no longer be funded) by the Ministry. Accordingly, the Hospital ceased maintaining the GRASP Workload Measurement system in early 2006. Nursing-specific workload measures are therefore not available.

In lieu of nursing-specific workload indicators, the IAC reviewed the Case Mix Groupings (CMG) data for the Hospital. The top 10 CMGs for surgery for the period April to October 2006 (the latest date for which data was available to the IAC) comprise 50% of the total admissions to the Inpatient Surgical Units, and so provide at least a partial quantified view of the resource/patient care requirements.

Table 4

<table>
<thead>
<tr>
<th>Unit</th>
<th>CMG Ranking within Surgical Program and Description</th>
<th>Number of Cases</th>
<th>ALOS</th>
<th>ARIW</th>
<th>Total Weighted Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 South</td>
<td>#2: Knee replacement</td>
<td>274</td>
<td>5.1 days</td>
<td>2.0234</td>
<td>554.4</td>
</tr>
<tr>
<td></td>
<td>#3: Hip replacement</td>
<td>207</td>
<td>5.6 days</td>
<td>2.2848</td>
<td>472.95</td>
</tr>
<tr>
<td></td>
<td>#7: Major lower/upper extremity procedure</td>
<td>98</td>
<td>3.9 days</td>
<td>1.1309</td>
<td>110.83</td>
</tr>
<tr>
<td>6 North</td>
<td>#1: Major uterus / adenexal procedure, no malignancy</td>
<td>317</td>
<td>2.9</td>
<td>0.8949</td>
<td>283.67</td>
</tr>
<tr>
<td></td>
<td>#4: Major intestinal / rectal procedure</td>
<td>132</td>
<td>11.5</td>
<td>2.9030</td>
<td>383.19</td>
</tr>
<tr>
<td></td>
<td>#5: Simple appendectomy</td>
<td>129</td>
<td>2.1</td>
<td>0.6219</td>
<td>80.22</td>
</tr>
<tr>
<td></td>
<td>#6: Femur/pelvis procedure for trauma</td>
<td>119</td>
<td>11.6</td>
<td>2.2875</td>
<td>272.21</td>
</tr>
<tr>
<td></td>
<td>#8: Skin graft/wnd Db</td>
<td>83</td>
<td>1.6</td>
<td>0.8645</td>
<td>71.75</td>
</tr>
<tr>
<td></td>
<td>#9: Abortive outcome with D&amp;C</td>
<td>68</td>
<td>1.0</td>
<td>0.2700</td>
<td>18.36</td>
</tr>
<tr>
<td></td>
<td>#10: Laparoscopic cholesysteomy</td>
<td>67</td>
<td>4.7</td>
<td>1.0227</td>
<td>68.52</td>
</tr>
</tbody>
</table>
As indicated in Table 4,

- the number of cases within the 10 top CMGs was
  - 579 on 6 South
  - 915 on 6 North

- the weighted Average Length of Stay (ALOS) within the 10 top CMGs was
  - 5.06 days on 6 South
  - 5.03 days on 6 North

- the weighted Average Resource Intensity Weight (ARIW) within the 10 top CMGs was
  - 1.9657 on 6 South
    - 83% of the cases had a weighted ARIW of 2.14
    - 17% of the cases had a weighted ARIW of 1.13
  - 1.2873 on 6 North
    - 27% of the cases had a weighted ARIW of 2.611
    - 73% of the cases had a weighted ARIW of 0.7869

The IAC interprets this data to indicate that when the two units are compared:

- On 6 South
  - the resource requirements of the majority of cases (83%) was high (weighted ARIW 2.14) and the length of stay was long (weighted average 5.32 days) and
  - the resource requirements of the minority of cases (17%) was low (weighted ARIW 1.13) and the length of stay was short (weighted average 3.9 days)

- On 6 North
  - the resource requirements of the majority of cases (73%) was low (weighted ARIW 0.7869) and the length of stay was short (weighted average 2.56 days) and
  - the resource requirements of the minority of cases (27%) was very high (weighted ARIW 2.611) and the length of stay very long (weighted average 11.55 days)
2.2 Historical Development of the Professional Responsibility Complaint

As noted in Part I, Section 1.2, concerns regarding workload/professional responsibilities on the Inpatient Surgical Units have been ongoing since 2004. Since September 2004, 36 Professional Responsibility Workload (PRW) Reports have been submitted: 2 in 2004, 12 in 2005, 22 in 2006 and none-to-date in 2007. Only one (1) PRW Report has been submitted since the new Clinical Director assumed her position in October 2006. When asked about this by the IAC, the RNs indicated that they wished to ‘give the new Manager a chance’ and to ‘cut her some slack’, and that the decrease in reporting does not reflect a lessening of or resolution of the issues.

The Hospital and the Association, including the Registered Nurses on the Inpatient Surgery Units, are to be commended for the effort and time they have put towards identification of and discussion of issues. Concerted documented efforts have been ongoing since 2004.

The Registered Nurses and Registered Practical Nurses on the 6th floor (which at the time included an additional Unit (6 Centre) as well as 6 North and 6 South) held an off-site meeting on October 21, 2004 to address issues and concerns on the Inpatient Surgical Units. The nurses identified seven key issues of concern (portering, clinical assistant, service room and supplies, housekeeping, equipment, staffing and communication) and identified suggested solutions to address them. The nurses met with the (then) Clinical Director on November 8, 2004 to discuss these seven issues impacting practice and workload.

In response to the identified concerns the Clinical Director struck an Inpatient Unit Task Force, which met on January 30, 2005. The Task Force recommended a new staffing model, which “split” the 6th floor into distinct units, with the nursing staff being dedicated to one specific unit, rather than the 6th floor as a whole. This decision was implemented in September 2005, with a new staffing model. The Inpatient Unit Task Force did not appear to have met again.

The Hospital Association Committee (HAC) met regularly throughout 2005. The PRW Reports submitted by the Inpatient Surgery RNs were discussed at HAC on an ongoing basis, though no resolutions relating to the Inpatient Surgery issues were documented. At the December 21, 2005 HAC meeting, the decision was made to ‘discuss and review the workload complaint process as per the Collective Agreement’ at the January 2006 HAC meeting.12

The Inpatient Surgical Units held a staff meeting with the Vice President, Surgical Services and the Director of Human Resources on January 16, 2006. Representatives from the Executives of the Association and the CAW (representing RPNs), 19 RNs, and 16 RPNs attended. This meeting, the notes of which suggest honest and open discussion, led to the creation of a Core Group, which met seven times between January 30, 2006 and June 23, 2006.

The Core Group was comprised of RNs and RPNs from 6 North and 6 South, Local 139 Bargaining Unit President, the Clinical Director and Educator/Practice Lead for Inpatient Surgery, and the Vice President Surgical Services. The purpose of the Core Group was to ‘identify issues of concern, identify possible solutions, set action and targets, move forward together, take joint responsibility and create change’.13 Among other things, the Core Group proposed a revised staffing pattern, reviewed data from comparable community hospitals from the MOH-LTC “Hospital Functional Centre Indicator Tool”, met with Managers of the Linen and Supply Departments, and developed a new master rotation schedule based on the premise that the

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12 Quotation drawn from minutes of December 21, 2005 HAC meeting.
13 Quotation drawn from the “Roles” section of the March 23, 2006 Core Group Report to Staff.

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OBS Unit would move and the evening Operating Room hours would decrease by 4 hours. (This schedule was implemented in September 2006, even though these two changes did not occur). The final meeting of the Core Group was held on June 23, 2006. The notes from the meetings, together with the comments made at the Hearing by both the 6th floor RNs and the Hospital, suggest that the Core Group was an effective forum for discussion and partial resolution of at least some issues (e.g. revision of the linen quotas, development and implementation of a new schedule). The active involvement of the (then) Vice President Surgical Services (now Acting President and CEO) appeared to be very valued by the nursing staff. However, it appears that the RNs felt that their concerns would not/could not be effectively addressed through the Core Group, and that they made the decision to move forward under Article 8.01 of the Collective Agreement following the June 23, 2006 meeting.

Due to scheduling difficulties over the summer, the RNs, with representatives from the Association (Professional Practice Specialist and Servicing Labour Relations Officer) did not meet with the Hospital until the September 14, 2006 HAC Meeting to discuss formally moving the issues of concern to the level of a Professional Responsibility Complaint.

The Hospital responded on September 29, 2006, outlined its recognition of the issues and plans to address them, and asked that the Association consider deferring the decision to move to a Professional Responsibility Complaint until December 2006, to enable evaluation of the new (implemented in September 2006) master rotation schedule, relocate the Observation Unit and 'the other efforts that have been undertaken'\footnote{Quotation drawn from September 29, 2006 letter from Patrick Gaskin (Acting President and CEO) and Gloria Whitson-Shea (Vice President Nursing) to Kathi Wilkins-Snell (Servicing Labour Relations Officer, ONA) and Mariana Markovic (Professional Practice Specialist, ONA).}

The Association responded on October 2, 2006, stating that it did not believe that the proposed solutions would satisfactorily resolve the entire problem, identifying its nominee to the IAC, and requesting the Hospital to do the same. In accordance with Article 8.01 (a) (v) requiring the Association to forward a written report outlining the complaint and recommendations to the Chief Nurse Executive, the Association wrote to Gloria Whitson-Shea on October 26, 2006.

The initial IAC was constituted in November 2006. As the Chairperson withdrew for personal reasons in January 2007, the Committee was reconstituted in February 2007, with the selection of a new Chairperson. The Association formally reiterated the unresolved concerns in a letter to the IAC on March 20, 2007 (Appendix I).
2.3 Hearing Presentations

The Hearing was held on April 17 – 19, 2007. The process of the Hearing was structured such that each of the Association and the Hospital made a 90 minute oral Submission presentation, highlighting the key elements of their previously submitted written Brief and Exhibits. On the following day, each of the Hospital and the Association made a Response presentation, during which each party clarified/discussed/challenged information presented by the other in its oral and written submissions.

2.3.1 Ontario Nurses’ Association Submission Presentation

The Association presentation was comprised of a written Brief, including 22 exhibits of supporting/explanatory material, and an oral presentation led by Mariana Markovic.

The Association indicated that Article 8 of the Collective Agreement is specific to the issue of professional responsibility. This clause exists in the Collective Agreement because of the expectations regarding professional practice as outlined in the Regulated Health Professions Act and the College of Nurses of Ontario Professional Standards. The Association stated that the guiding principle is that the goal of professional practice is to obtain the best possible outcome for patients with no unnecessary exposure to risk of harm.

The Association referenced an experience that occurred that morning during the Site Tour of the Inpatient Surgical Units. Coincidentally, a Registered Nurse, who had formerly worked on 6 North, was on the Unit visiting a patient at the time of the Site Tour. The Registered Nurse expressed her belief that nothing has changed, in terms of the issues of concern that led her to transfer from 6 North three years ago.

The Association stated that despite efforts since 2004, resolutions relating to nurse staffing, patient acuity, fluctuating workloads and fluctuating staffing have not been achieved. Most concerning is the lack of discussion between staff and Management through the PWR process; there has been no response from Management to any of the 36 PRW forms submitted since 2004, or resolution of any issues as a result of discussion at HAC.

The Association stated that while the Hospital has taken steps to resolve some of the issues, these steps were temporary or the exact date of implementation could not be pinpointed, and that it was very difficult to get the Hospital to commit on paper. The Association cited the OBS Unit as an example. Although the OBS Unit is located on the 6th floor, it functions as a surgical step-down from the Intensive Care Unit. Now that funding for Critical Care Response Teams (CCRT) has been received from the MOH-LTC, there is a need to move the OBS Unit from the 6th floor. The Hospital indicated in June 2006 that the OBS Unit would move, but to date, this has not occurred. The Association suggested in October 2006 that an additional staff member be added to each of 6 North and 6 South, until the OBS Unit moved, in recognition of the number of vacant positions, but no feedback has been received from the Hospital.

The Association grouped the numerous concerns expressed by Registered Nurses into three main areas:

- Nursing workload: inappropriate patient assignment, inadequate staffing base of full-time and part-time staff, unfilled vacancies on the schedule, high overtime, high sick time, no sick call replacement;
• **Nursing resources**: low or minimal patient supplies, lack of equipment, minimal support staff for access, portering, housekeeping; and

• **Nursing leadership**: retention and recruitment problems (resulting in inadequate staffing, 25 RNs and RPNs leaving the unit), poor communications with nursing staff, no follow through of unit plans with organizational direction, unhealthy work environment.

With respect to nursing workload issues, the Association stated that it is important to consider the type of work nurses are doing on the Inpatient Surgical Units. The Surgical Units are acute trauma units, requiring additional competencies and skills beyond that of basic nursing preparation.

• Edie McMyler described a ‘typical day’ on 6 North. She stated that the day is extremely busy, a 1:5 nurse:patient ratio is a heavy workload, especially given the need to make oneself available for consultation with the RPN and care as required for the RPN’s patients. She stated that nurses are lucky to get a break before 0930 or 1000, are lucky to get lunch and never get a supper break. The unit is very busy from 1530 on, with post-op patients returning to the floor anytime after 1100 hours.

• Janet Hintermayer described a ‘typical day’ in the Observation Unit. She stated that changes in patient status/stability occur quickly, requiring constant vigilance. In addition to the general surgical procedures (e.g. dressings), some patients require specialty procedures such as intrapleural analgesia (IPA), which requires 40 minutes of 1:1 nursing care several times a day. Transfer of patients in and out of the OBS Unit occurs frequently, to accommodate patients who are deteriorating and/or require more focused assessment and observation.

• Shannon Wright described a ‘typical day’ on 6 South. She stated that the majority of care (e.g. assisting a patient to the bathroom) requires two nurses, and that many of the patients receive IV medications, epimorph or PCA, and require frequent monitoring to assess sensation and movement.

• Jorja Lamb reviewed the challenges associated with the Resource Nurse role, including the fact that continuity of patient care planning has been negatively impacted by the 2-days-on / 2-days-off rotation implemented in September 2006.

• The staffing base is inadequate: when reviewing the actual schedule of RN staff, it is difficult to identify full-time and part-time staff due to the large number of vacancies, and part-time staff filling full-time lines, which leaves few resources to call for short-term replacements.

• There is high sick time; on 6 South on the 31 days in March 2007, a staff member (5 RN, 9 RPN) was sick on 14 of the 62 shifts, and was replaced on 13 shifts (usually by an RN or RPN from the Float Pool).

With respect to nursing resources:

• During the mid-morning Site Tour, only one of the four linen carts was complete, the other three carts did not have washcloths, necessitating the nurses to make an extra trip to obtain required supplies from a different cart, taking time away from patient care.

• The Hospital has taken steps to improve the availability of equipment, such as BP cuffs, spot monitors for each team, designated equipment for isolation rooms; however, other equipment, such as IV poles are still required.

• Portering hours are minimal, which impacts the Surgical Units due to the large volume of patient transfers between PACU, ER, creation of male/female rooms to facilitate admissions.

• The Clinical Assistant, though technically available for both 6 North and 6 South, spends more time on 6 South with the orthopedic patients.

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With respect to nursing leadership:

- Recruitment and retention issues have been problematic, as 25 RNs and 12 RPNs have left the 6th floor over the past two (2) years; although it is recognized that nurses move for a variety of reasons, the high number suggests the need to look at the environment itself.
- There is a consistent lack of follow-through and poor communication on the part of the Hospital, e.g., the move of the OBS Unit, lack of completion of response to the PRW forms by Hospital management.
- The Association stated that reflecting back on the past two (2) years, the Inpatient Surgical Units have been an unhealthy work environment. No-one wants to come and work on these units, which is very discouraging and symptomatic of the work environment.

The Association concluded its presentation by reviewing its proposed recommendations regarding staffing. The specific recommendations proposed by the Association are included in Appendix VIII.

2.3.2 Grand River Hospital Submission Presentation

The Grand River Hospital presentation was comprised of a written Brief, including 22 Exhibits of additional/explanatory material, and an oral presentation by Rusty McIay. In addition, the Hospital distributed an Addendum with 7 Exhibits, in response to the IAC’s request of April 5, 2007.

The Hospital opened its presentation with comments from Patrick Gaskin. He stated that he is concerned that the perception may be that the Hospital does not value the role of nursing or recognize the importance of nursing staff. He stated that he believes that the Hospital does indeed value its staff, and that the Hospital has made genuine efforts through the Core Group to deal with issues as simple as linen and as complicated as staffing, that issues have been taken seriously and that there has been forward movement. He stated that the Hospital is committed to continuing this progress, within the necessity to balance appropriate levels of care with available resources. The Hospital is currently under Supervision, and is being pushed to be as operationally and fiscally efficient as possible. He stated that there have been and continue to be positive relationships between the Bargaining Unit and Management, that the Hospital has benefited from this positive relationship, and that it is committed to ensuring the relationship does not deteriorate.

The Hospital’s comments included the following:

- It is the Hospital’s view that the Hospital has or is implementing the resources, programs and strategies necessary to provide workload consistent with proper patient care requirements using current resources.
- The Hospital believes that Article 8 of the Collective Agreement is intended to deal with issues in a timely way as the issues arise. Although PRW forms dating from 2004 have been included in the Association Brief, the Hospital believes the IAC’s recommendations need to focus on current resources and current circumstances in a forward-looking manner.
- The Hospital believes that the Association’s focus on 2004 and prior concerns undervalues the hard work that has been done since 2006. In particular, a substantial number of changes have occurred within the Inpatient Surgical Program since October 2006, emanating from the appointment of the new Clinical Director. Of particular note, only one PRW form has been received since October 2006, and the Clinical Director did respond as required under Article 8.
The Core Group struck in January 2006 was a Management response to workload complaints. The minutes of the Core Group meetings clearly indicate that there was an open opportunity for input by all members including Registered Nurses, there was discussion on all the key issues, and that forward movement on a number of tough issues was achieved.

- An example is the decision to reconfigure the Resource Nurse schedule to cover weekends, in response to concerns expressed by the nursing staff. Since making the change, there has been discussion with the Clinical Director regarding the optimal use of the Resource Nurse resource, and whether the change is working as originally hoped. From the Hospital’s perspective, the process is effective: there was a suggestion, an implementation, now in monitoring and feedback mode.
- A second example is the recognition on the part of Management (Clinical Director) that the September Master Rotation was not evenly balanced. Steps were taken to revise the schedule, with the input of staff nurses.

The timing of the referral of the workload concerns to the IAC in the fall of 2006 is unique given the number of initiatives currently underway to address the issues. While the Hospital appreciates the Association’s right and reasons to do so, the Hospital believes that the referral has been made at a time when significant change on the 6th floor is not being recognized or given the credit deserving in the circumstances.

With respect to workload,

- The Hospital believes that the current manner of patient assignment is appropriate and that no recommendation is required. The Resource Nurses currently do an excellent job with respect to patient assignment, and have the opportunity to discuss any issues in their monthly meeting with the Clinical Director.
- The Hospital believes that the staffing levels on the Inpatient Surgical Units are appropriate. In particular, the Hospital noted that the staffing levels are the same on Nights as on Days, which is not frequently found in other hospitals.
- The Hospital recognizes that the delay in moving the OBS Unit from the 6th floor has created difficulties for the schedule. The move is now confirmed for May 22, 2007. Once this occurs, the Part-Time Registered Nurses will no longer need to be pre-booked to cover the OBS Unit, which will provide increased flexibility for short-term staffing. In addition, the 1:5 nurse:patient ratio will be consistently achieved throughout the 6th floor.
- The Hospital stated that unfilled vacancies are no longer a significant issue. Lines are being filled in the normal course of recruitment, and unfilled vacancies are not impeding workload on the 6th floor. The Hospital does not believe that a recommendation is required in this area.
- With respect to overtime, the Hospital indicated that overtime is 3.8% of total time worked in Inpatient Surgery, which is not excessive, either on face or in comparison with other units within the Hospital. In addition, the Hospital believes that overtime is decreasing, and that the number of full and partial shifts of overtime is less in the first 3 months of 2007 than in 2006.
- With respect to sick time, the Hospital believes that sick time levels are not excessive on a day-to-day basis (approximately 6.23% or 6 tours per year per nurse). The Hospital feels that the issue of sick time is largely historical, in light of the recent changes made in the Staffing Office and Float Pool.

With respect to resources,

- The Hospital feels that linen supply issues were dealt with at the Core Group and Unit Council through discussion with the Manager of Supplies and Stores. There has been a change of management in the linen area; it is the Hospital’s position that there has been an improvement.

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• The two Late Career Initiatives relating to supplies (reorganization of the supply area to increase efficiency) are ongoing. In addition, new equipment has been ordered, and a mechanism for maintenance of equipment has been formalized. The Hospital does not believe that a recommendation in this area is warranted.

• With respect to Portering, the Hospital is finalizing Guidelines for Transportation after 1830 hours, which will confirm that the 6th floor nurses will be the third point of contact for transportation requirements.

With respect to leadership,

• The Hospital is concerned that the Association’s Brief does not focus on late 2006 and 2007 to date, since the new Clinical Director assumed her position. Her desire is to have an open, visible presence on the floor, and there is substantial documentation (e.g. Staff Meeting Minutes, Unit Council Minutes) suggesting that open communication does indeed exist.

• In addition, Organizational Development has been engaged and will be doing some ‘morale and culture’ work with the staff in the near future, and a Hospital-wide Staff Satisfaction Survey will be implemented first on the 6th floor.

The Hospital closed its presentation by stating that the complaint and the involvement of the IAC arises at a unique time because there is a significant body of evidence that a lot of work has been done to date, and that recognition of these initiatives is the appropriate thrust of what the IAC’s focus should be over the next 2-1/2 days.

The specific recommendations proposed by the Hospital are included in Appendix IX.

2.3.3 Ontario Nurses’ Association Response Presentation

The Association opened its Response presentation by expressing appreciation for the introductory comments made by Patrick Gaskin, and reflecting on the Hospital’s Mission Statement that speaks to ‘exceptional care with compassion’.

The Association reiterated its belief that the PRW form is intended to be a communication tool between Registered Nurses and Management, and that the Association believes the Hospital’s interpretation of its responsibility is different from the Association’s interpretation. The Hospital has been receiving PRW forms from the Inpatient Surgical Units since 2004, but has not implemented a process to allow for resolution at the second step: there is currently no mechanism for a Registered Nurse to advance her/his concern regarding workload beyond the Administrator On-Call. There is no decision tree (such as to call the Chief Nursing Officer) if the response is ‘no staff available’. ‘No staff available’ is a response, not a timely resolution of the issue. The Association also highlighted the fact that the phrase ‘using current resources’ exists only in Article 8.01(a)(i), to encourage nurses to work with their peers on the unit to discuss how best to work within the resources available at the time. The phrase ‘using current resources’ does not refer to decision-making beyond 8.01(a)(i).

The Association reviewed in detail its perspective regarding a number of the issues identified in the Hospital submission, including availability of nursing resources and nursing leadership, number of vacant positions, extent of overtime and sick time, communication, and plan for movement of the OBS Unit. The Association then provided its perspective on each of the recommendations included in the Hospital’s Submission, and expressed its concern regarding the lack of measurable evaluation outcomes.
The Association closed its Response presentation by highlighting the results of the College of Nurses of Ontario Practice Setting Consultation Program (PSCP) survey completed by Registered Nurses at the Grand River Hospital in the fall of 2003. The Association stated that the issues identified in the 2003 PSCP survey, both at a corporate and program specific level, are consistent with the issues under consideration now, and that no follow-up actions have been taken.

2.3.4 Grand River Hospital Response Presentation

The Hospital provided a short written submission, highlighting its Response comments. The Hospital reiterated its concern regarding the timing of the referral to the IAC in the fall of 2006, when substantial changes were occurring to address identified issues within the Surgical Program, and reaffirmed its belief that

- the current baseline staffing, which will provide for a consistent 1:5 nurse:patient ratio once the OBS Unit is relocated on May 22, 2007, is appropriate;
- the revision to the Resource Nurse schedule was made in consultation with the RNs on the 6th floor through the Core Group, and the current schedule is being evaluated;
- there is no requirement for an additional Clinical Assistant position or additional Housekeeper positions;
- current staffing resources are adequate (there are not a large number of outstanding vacancies, overtime is decreasing, sick time is not excessive).

The hospital concluded its Response by stating that it believes there have been significant good faith efforts with extensive involvement of the nurses on the 6th floor to deal with the issues that have arisen, and that the focus for both the IAC and the Inpatient Surgical Program needs to be ‘go forward’ rather than ‘look back’.

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PART III: DISCUSSION AND RECOMMENDATIONS

3.1 Introduction

The IAC believes that through the Hospital’s and Association’s written submissions and exhibits, the oral presentations and discussion, and the thoughtful and respectful comments made in response to questions posed by the IAC at the Hearing, it has been able to obtain a comprehensive understanding of the professional workload issues relating to the Inpatient Surgical Program. The active participation of both a large number of Registered Nurses and members of the Senior Management team gave the IAC a very positive message that both the Hospital and the staff are concerned about the issues, and that they wish to move forward to achieve mutually agreeable resolutions.

The IAC has based its comments and recommendations on the perspective that ‘nursing workload’, both actual and perceived, is impacted by and must be understood within the context of the practice environment. The practice environment includes both direct factors, such as role responsibilities, patient acuity/care needs and staffing resources, and indirect factors, such as leadership, communication, opportunities for development and processes and systems of care. A practice environment that respects and supports the professional practice of nurses will result in the provision of effective and efficient care of patients and retention of health care staff.

The IAC believes that the key issues impacting the current practice environment within the Inpatient Surgical Program relate to staffing, resources and leadership. Although the research literature indicates that other factors, such as appropriate professional development support, effective multi-disciplinary relations etc have an impact on the quality of the practice environment, it was apparent to the IAC that these factors do not appear to be an issue of concern within the Inpatient Surgical Program. Accordingly, the IAC has focused its analysis and recommendations within the “nursing workload”, “nursing resources” and “nursing leadership” framework presented by both the Association and the Hospital.

3.2 Nursing Workload

As discussed above, the factors influencing ‘nursing workload’ relate to the supply of health care and other resources in relation to the demands of patient care needs. The optimal goal is that the health care needs of patients and their families can be met, effectively and without undue duress, by the resources of the health care team. Therefore, evaluation of ‘nursing workload’ requires an analysis of both the supply (staffing and physical resources) and demand (patient acuity/care needs) elements.

3.2.1 Inpatient Surgical Program Nursing Staffing Resources

The IAC’s comments regarding the required nursing staffing resources for 6 North and 6 South are predicated on the assumption that the OBS Unit will be moving to the second floor as of May 22, 2007 and that 6 North will move from 36 to 40 inpatient beds\textsuperscript{15}.

\textsuperscript{15} The Hospital was unequivocal at the Hearing that the OBS Unit would move on May 22, 2007. The IAC had some reservations as to whether this would in fact occur, due to the volume and nature of outstanding issues yet to be resolved.

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3.2.1.1 Nursing Staff Scheduling

The Association and the Hospital indicated to the IAC that they each believe that a 1:5 nurse:patient ratio is appropriate for 6 North (excluding the OBS Unit) and 6 South. The IAC agrees with this ratio, in light of the apparent care needs/acuity of the surgical patient population, and in light of the geographical layout of the two units. Therefore, the IAC believes that the total number of direct care providers (as indicated by the number of ‘lines’ on the Master Rotation for both 6 North and 6 South) is appropriate and does not require revision. However, the IAC also believes that the 1:5 nurse:patient ratio should not be exceeded, and that in the event of short-staffing, beds should be closed as required in order to ensure that this ratio is not exceeded.

The Association’s Brief and comments at the Hearing indicated the following concerns regarding nursing workload: inappropriate patient assignment, inadequate staffing base of full-time and part-time staff, unfilled vacancies on the schedule, high overtime, high sick time, and no sick call replacement.

With respect to patient assignment, the IAC believes that the current practice of patient assignment being determined by the Resource Nurse/Charge Nurse is appropriate. Although the consistent allocation of RN/RPN teams to designated rooms can result in unbalanced care requirements across teams (i.e. one RN/RPN team could have patients with high acuity/care needs while another team has patients with lower acuity/care needs), the IAC can understand the decision to maintain consistent team assignments in light of the geography of the Units. The IAC assumes that day-to-day changes to the team assignments are made by the Resource Nurse when necessary to effectively balance patient care needs with RN/RPN skill mix and resources. With respect to the balance of RN/RPN skill mix, the comments made by both the Hospital and the nurses at the Hearing convinced the IAC that increasing the proportion of RNs is not currently warranted; the comments indicated strong support for the clinical expertise of the RPNs, who are felt to be practicing at a full scope of practice. With respect to moving from a team nursing framework to an alternative framework, such as total patient care, the IAC believes that this is an option that the Program may wish to explore, especially on 6 North, where the range of patient acuity varies quite considerably. However, the RNs would continue to be responsible for care provision beyond the RPNs’ scope, so the impact would not be extensive.

With respect to the staffing base and number of vacancies, the IAC did not gain a crystal clear understanding of the number of Master rotation lines currently filled by full-time nurses vs. those filled on a temporary basis (e.g. filling in for a Maternity Leave) by part-time nurses. The Surgical Units have a fair proportion of younger staff, and will have, by definition, fairly constant movement as nurses go on Maternity Leave, Education Leave etc. Although the IAC recognizes the substantial turnover in nursing staff over the past two years (25 RNs and 12 RPNs), at the time of the Hearing there were only four vacant positions, which did not appear excessive. The Hospital has recently created a Recruitment Coordinator position to focus on RN/RPN recruitment, and the IAC assumes the Hospital will take full advantage of all nurse-recruitment initiatives available through the MOH-LTC. The IAC believes that the specific number of full-time vs. part-time staff within the Master Rotation lines is not the key factor impacting day-to-day staffing stability. The key is that there always be sufficient part-time and casual staff who are not pre-booked to their committed hours and who are therefore available for short-term staffing needs (e.g. sick time replacement, alterations in patient acuity). The fact that the full-time and regular

addressed at the time of the Hearing (one month prior to the move date). If the OBS Unit does not transfer, 6 North will need to block one bed to achieve the required 1:5 nurse:patient ratio across all teams on all shifts.

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part-time staff are being regularly called for extra shifts (sometimes being ‘ordered in’) indicates that there is a significant problem with the availability of relief staff.

The IAC believes that the Hospital needs to evaluate the true availability of relief nurses in terms of the number of long-term vacancies (such as Maternity Leaves, into which part-time and casual staff are pre-booked), the average number of short-term replacement (i.e. sick time, acuity) requirements, and the availability of casual and Float Pool staff (i.e. casual staff working at more than one facility and therefore frequently unavailable to Grand River when called, vacancies in the Float Pool) etc.

A number of changes have, or will be occurring, which will impact the availability of short-notice relief support.

- The IAC recognizes that staffing flexibility has been substantially negatively impacted, since September 2006, by the need to provide one (1) RN 24/7 from within the part-time RNs to staff the OBS Unit. This requirement will cease after May 22, 2007, which should decrease the number of part-time staff who are pre-booked to their committed hours. However, moving the OBS Unit may have an impact on the acuity/care needs of patients who remain on the 6th floor, if patients who would have moved into the OBS Unit based on nursing judgment (e.g. for enhanced observation) remain on the floor as they do not meet the “medical” criteria for admission into the StepDown Unit,
- Changes to the Staffing Office (relocation of the Staffing Clerk to within the Surgical Program geographical area) as of April 1, 2007 should have a positive impact, as the Program Staffing Clerk will be, both virtually and physically, more a member of the team.
- The creation of the ‘mini Float Pool’ for the Critical Care and Emergency Departments should result in greater availability of the Float Pool resources for the Surgical Inpatient Program.
- The new Master Rotation was implemented on April 6, 2007, and will require several months to ‘shake out’.

In addition, the IAC believes that the actual process for staffing short-notice relief requests could be simplified. Currently, the Resource Nurse (Charge Nurse on Nights/Weekends) calls the Manager (Days: Clinical Director; Evenings: Clinical Administrator; Nights: Administrator-on-Call) to obtain approval to call replacement staff and to authorize premium shifts if required. The IAC believes that the Resource Nurse/Charge Nurse is in the most knowledgeable position regarding the Unit staffing in light of patient care needs, and so should have the authority to make decisions regarding required staffing independently.

The IAC recommends that

1. The Clinical Director monitor the balance between relief staff availability and relief requirements for six months (June 1, 2007 to November 30, 2007) to identify the number of shifts that are replaced by
   (a) Surgical Program part-time (within committed hours) and casual staff,
   (b) Float Pool staff, and
   (c) full-time and part-time (outside of committed hours) on a premium basis.

2. The Clinical Director work with the Recruitment Coordinator to hire additional staff (casual and full-time/regular part-time term (time-limited) positions) to ensure that full-time and part-time (outside of committed hours) will never be required to work overtime (premium time) to meet short-notice relief requirements.
3. **The Clinical Director** evaluate the new Master Rotation for the period April 6, 2007 to September 30, 2007 (6 months) to determine
   - the number of shifts where the schedule as defined varies (because RN is replaced with RPN or vice versa, or because short-notice relief needs are not met)
   - the number of shifts RNs/RPNs called in sick
   - the number of overtime (premium pay) shifts
   - the balance of novice-to-expert resources within each 24 hour period, and within each Unit
   - the number of times short-term relief needs could not be met by part-time/casual staff and Float Pool
   - qualitative level of satisfaction of RNs and RPNs
   And, based on the above evaluation, work with the Unit Council to collaboratively identify and implement any required changes.

4. **The Clinical Director** monitor the impact of the transfer of the OBS Unit on the acuity/care needs/workload on the 6th floor and work with the Vice President Nursing and Chief of Surgery to ensure that the criteria for transfer into the StepDown Unit do not preclude nurses’ autonomy to transfer patients who require enhanced assessment or complex interventions into the Unit.

5. **The Resource Nurse** (or Charge Nurse on Nights/Weekends) have the authority to call staff for short-term replacement / patient acuity needs independently, in accordance with the Central and Local Collective Agreements regarding seniority.

With respect to **overtime and sick time**, the IAC believes that the impact of both sick time and overtime on the nursing staff is much higher than the actual numbers would suggest because of the fact that nurses are requested to work premium (extra) shifts and to work beyond their scheduled shifts and through scheduled breaks on a regular basis. The IAC did not find the actual levels of sick time to be excessive in light of industry standards. The IAC was concerned that the nurses’ perception was that overtime is a daily reality, while the data regarding premium hours paid indicated that overtime is decreasing. While the IAC understood the nurses’ decision to ‘hold off’ on reporting overtime to enable the Clinical Director to settle into her role, this cannot be a long-term approach for two reasons: the Clinical Director cannot address a problem that she is not aware of, and continuing to work but not report overtime will lead to frustration and a sense of being taken advantage of. The IAC encourages the RNs (and RPNs) to follow the parameters of their Collective Agreements.

3.2.1.2 Resource Nurse Role

The Resource Nurse role is pivotal for the smooth coordination of care needs on both 6 North and 6 South. In light of the fact that the Clinical Director’s role is more administrative than clinical and that she has significant accountabilities in addition to the Inpatient Surgical Program, responsibility for day-to-day operational management of the Units falls to the Resource Nurses. It was evident to the IAC that the Hospital recognizes the importance of the Resource Nurse role, as it has designated four expert nurses to fill the role on a full-time basis, and maintains the Resource Nurse schedule separate from the main master rotation.

Previous to September 2006, the four Resource Nurses worked days and evenings Monday through Friday on each of 6 North and 6 South. The decision to re-allocate 3.75 hours per evening to enable weekend Resource Nurse coverage was based on the perceived need for

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enhanced coordination on the weekends, and on the expectation that the OBS Unit would move from 6 North and that the Operating Room schedule would decrease by four hours per evening.

The IAC understands that this decision was made by the Core Group and involved both the nurses and Hospital management, and that the Hospital believes that evening and Sunday activity on the inpatient units should continue to be monitored ‘to determine the appropriate utilization of the Resource Nurse on a go-forward basis’. The IAC believes that the experiences of the past six months are sufficient evaluation, and that further monitoring will not result in new information.

The IAC supports returning to Resource Nurse coverage from 0700 – 2300 hours Monday through Friday, with each Resource Nurse scheduled for a continuous five-day period, for the following reasons:

- Although transfer of the OBS Unit from 6 North to the 2nd floor will have an impact on 6 North (e.g. result in less transferring of patients between the floor and the Unit) coordination of care needs for those patients whose condition deteriorates or who require enhanced nursing care above a 1:5 ratio will still be required. Transfer of such patients into the new Stepdown Unit will be more complicated than the current simple nurse-managed internal transfer, and will be difficult for the floor RN to effectively accomplish while caring for four other patients (and covering responsibilities for her/his team RPN’s five patients). Coordination of the transfer, including reallocation of nurse:patient resources on the floor as required, by the Resource Nurse will support quality patient care.

- The Hospital confirmed at the Hearing that it has no concrete plans to decrease the current Operating Room evening schedule. Therefore, if beds are available on the inpatient surgical units, urgent and elective surgeries will continue to be performed, and post-operative patients will continue to arrive on the Units well into the evening.

- The current 2 day on / 2 days off Resource Nurse schedule does not support continuity. Given the fluctuating schedules of all of the other health care team members (in particular the RNs, RPNs and CCAC/Discharge Planners), it is extremely important that someone have the ‘big picture’ in order to recognize changes in patient status, anticipate requirements for in-hospital and post-discharge care, facilitate communication with other health care team members etc.

The IAC believes that the key elements are (a) coverage through the evening hours and (b) continuity through the week. Therefore, to maximize the impact of the Resource Nurse role, the IAC believes that the two Resource Nurses on each Unit should work an alternating two-week schedule (i.e. Week 1 – Days, Week 2 – Evenings). However, the IAC would support other options (e.g. permanent shifts), as long as the five-day continuity is maintained, and the schedule is within the constructs of the Central and Local Collective Agreement.

The IAC recommends that:

6. The hours of Resource Nurse coverage be increased by 3.75 hours Monday through Friday to cover Days (0700 – 1500) and Evenings (1500 – 2300) on 6 North and 6 South.

7. The Resource Nurse schedule be determined mutually by the Resource Nurses and the Clinical Director, with the caveat that the schedules maintain five-day continuity.

8. The revised Resource Nurse schedule be evaluated, using mutually determined criteria, by the Unit Council and Clinical Director, in January 2008.
3.2.1.3 Registered Nurse Staffing to Support Weekend Charge Nurse Role

Since September 2006, the weekend Charge Nurse role has been filled by a designated Resource Nurse, who has worked 0700 – 1900 on Saturday and 0700 – 1500 on Sunday. When the Resource Nurses return to a schedule covering Days and Evenings through the week, filling the weekend Charge Nurse role through the funded Resource Nurse positions will no longer be possible.

When a Charge Nurse role is not specifically funded, two options exist: an RN is pulled from patient care to cover the Charge Nurse responsibilities, resulting in a higher nurse:patient ratio for all remaining RNs/RPNs, or an RN assumes Charge Nurse responsibilities in addition to managing a full or partial patient care load.

In considering the impact of funded vs. non-funded Charge Nurse positions on 6 South and 6 North, the IAC considered the “10 Top CMGs” data, the “typical day” experiences referenced in the Association’s Pre-Hearing Brief and at the Hearing, census data, data re numbers of emergency surgical cases on the weekends, and the comments of both the Association and the Hospital at the Hearing. From this analysis, the IAC concluded that patient care activities on 6 North and 6 South differ.

On 6 South, the majority of patients have a length of stay averaging 5 days, and an ARIW of over 2.0.

- While the substantial care needs of the elective (e.g. hip and knee replacement) and urgent (e.g. fractured hip) orthopedic population are relatively predictable, the indirect care needs, such as need for enhanced mobilization support, and the unpredictable care needs, such as enhanced observation due to delirium and dementia, are fairly high.
- The data regarding numbers of emergency surgical procedures indicates that between 7.0 and 9.8 cases per day were completed on weekend days during the period January 1 – March 31, 2007. Some of these cases would have returned to 6 South.
- The census data (both midnight census data provided by the Hospital and 0700 census data provided by the Association) indicate that the number of occupied beds on the weekend is very similar to the number during the week, suggesting that there is not a lot of patient turnover on the weekend.
- This suggests that over the weekend:
  - the day-to-day workload is ‘heavy’ and relatively predicable;
  - several patients per day undergo operative procedures, and return to the ward requiring “fresh post-operative care”;
  - discharges can be anticipated/planned for;
  - frequency of admissions is stable

On 6 North, the majority of patients have a length of stay averaging 2.5 days, and an ARIW of less than 1.0, but a substantial proportion (almost 25%) have extremely high acuity/care needs (ARIW above 2.6) and a much longer length of stay (average 11.5 days).

- While the care needs of the majority of patients are less acute than those of 6 South, the frequency of admissions and discharges is much higher (2:1 ratio).
- The data regarding numbers of emergency surgical procedures indicates that between 7.0 and 9.8 cases per day were completed on weekend days during the period January 1 – March 31, 2007. The majority of these patients would have returned to 6 North.
- The census data (both midnight census data provided by the Hospital and 0700 census data provided by the Association) indicate that the number of occupied beds on the weekend is
less than that during the week, suggesting that patients are being discharged on Saturday and Sunday.

- This suggests that over the weekend:
  - the day-to-day workload is less consistent; some 5-patient assignments have short-stay lower acuity patients with 1-3 admissions/discharges per day, while other 5-patient assignments have long-stay, high care need patients;
  - higher proportion of patients are in their first or second post-operative day;
  - short-stay patients are being discharged, giving less time to plan for post-discharge needs.

The IAC does not support the Association’s recommendation of equal Charge Nurse coverage on 6 South and 6 North from 0700 to 1900 Saturday and Sunday. Based on the above analysis, the IAC believes that the need for funded Charge Nurse positions over the weekend differs between 6 South and 6 North. The IAC believes that 6 South requires a funded Charge Nurse position from 0700 – 1500 on Saturday, and that 6 North requires a funded Charge Nurse position from 0700 – 1900 on Saturday and 0700 – 1500 on Sunday, for the following reasons:

- Both 6 South and 6 North may receive post-operative patients from the PACU up to midnight on Friday night. Therefore, both Units may have first-post-operative day patients, requiring close assessment and interventions, possible requirement for transfer to the StepDown Unit or to other Departments (e.g. Medical Imaging) on Saturday. Pulling an RN from patient care to assume Charge Nurse responsibilities would increase the nurse:patient ratio above 1:5 and would not support optimal patient care.

- On 6 South, patient discharges on Saturday and Sunday can generally be anticipated some days in advance. Discharge planning can therefore begin during the week, when the CCAC-Discharge Planners are present. Final discharge coordination for both Saturday and Sunday discharges can be completed on Saturday, as the number of actual patients being discharged is fairly small.

- On 6 North, patient discharges are higher in number, and are for shorter stay and less predictable patients. Patient discharges on Sunday may not have been known on Friday. The higher number of patient admissions, transfers and discharges will result in medical orders, need for consultation/coordination with other health providers, increased numbers of family members visiting (and requiring time and support) etc. on both Saturday and Sunday.

The IAC recommends that

9. A Charge Nurse position be funded for 0700 – 1500 hours on Saturday on 6 South. The Charge Nurse will not carry a patient assignment.

10. A Charge Nurse position be funded for 0700 – 1900 hours on Saturday, and for 0700 – 1500 hours on Sunday on 6 North. The Charge Nurse will not carry a patient assignment.

3.2.1.4 Clinical Assistant Role

As explained by the Hospital during the Hearing, the Clinical Assistant is responsible for supporting RNs and RPNs to “assist in the maintenance or improvement of health, comfort, progress, mobilization, safety and cleanliness of the patient”\(^{16}\), including bathing patients.

\(^{16}\) Quotation drawn from March 8, 2007 posting (posting 0299-7) for a full-time Clinical Assistant on the 6th floor.

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assisting patients to the washroom and with ambulation etc, assisting with intra-unit transfers (bed moving) to accommodate male-female rooms and/or when patients move between the Units and the OBS Unit, portering patients to dialysis, ‘running’ to obtain required equipment and supplies etc. The intention is that the Clinical Assistant provides direct patient care assistance as requested/directed by the nursing staff. The Hospital stated that the Clinical Assistant is not expected to provide assistance to any other disciplines. The Clinical Assistant is required to have Health Care Aide or Personal Support Worker designation.

The Clinical Assistant role is currently shared between 6 South and 6 North Monday through Sunday on the day shift (0700 – 1500). Although the role appears to have been in place for some time, and although the intention was that the Clinical Assistant would provide support to both Units, there was agreement at the Hearing that the recently-retired full-time Clinical Assistant tended to focus on 6 South. The Hospital stated that it was clarified at the February 28, 2007 Staff Meeting that the newly-hired full-time Clinical Assistant is required and expected to focus on both 6 South and 6 North.

Based on analysis of the information included in the submissions and from discussion at the Hearing, the IAC was not convinced that additional Clinical Resources are required and so does not support the Association’s recommendation that two Clinical Assistant positions be added. From the information currently available, the IAC believes that one Clinical Assistant position, shared between the two Units on the day shift (0700- 1500) Monday through Sunday is sufficient and appropriate.

The IAC believes, however, that the Clinical Director needs to ensure that the ongoing implementation of the Clinical Assistant role (new person, implementation of companion phones, clarification of expected responsibilities on each Unit etc) is closely monitored to ensure that the role is effectively maximized. In particular, the Clinical Director will need to ensure that the Clinical Assistant assists nurses with physiotherapy as required, but is not responsible for direction of duties by the Physiotherapist (as was indicated in the recent job posting).

The IAC recommends that:

11. **The Clinical Director work with the CAW to modify the job expectations for the Clinical Assistant position on Inpatient Surgery to clarify that the Clinical Assistant receives direction regarding patient care activities from the Registered Nurses and Registered Practical Nurses, but does not receive direction from the Physiotherapist.**

12. **The Clinical Director monitor the ongoing implementation of the Clinical Assistant role to ensure that the role is effectively maximized on both 6 North and 6 South.**

3.2.1.7 Housekeeper Role

The housekeeping coverage on 6 South and 6 North is comprehensive between 0700 and 1800 hours. The IAC understood that the Association’s concerns regarding Housekeeping support relate to the lack of dedicated Housekeeping resources on the Units between 1800 and 2300 hours.

The IAC recognizes that Housekeeping is a corporate resource, management of which is outside of the authority of the Inpatient Surgical Program. The Inpatient Surgical Program does not have

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the autonomy to independently change the Housekeeper schedule or allocation, but can only request/recommend revision, based on evaluative data.

The IAC agrees that late (after 1800 hours) discharges and evening operative procedures impact cleaning requirements, and that the existence of an empty but uncleaned bed can be a source of considerable friction/angst between an inpatient unit and the Emergency Room or PACU. However, other than qualitative comments about the general need for housekeeping support, the IAC could not find sufficient data to justify the need for a dedicated Housekeeper between 1800 – 2300 hours. The IAC is therefore unable to support the Association’s recommendation for one additional Housekeeper on each Unit from 1500 – 2300 hours.

The IAC believes that the Clinical Director needs to develop and implement a system to monitor the requirement for unit-based Housekeeping support between 1800 – 2300 (e.g. number of times the general evening Housekeeper must be called by pager, number of times an admission is held in the ER or PACU because the bed/room has not been cleaned), and to discuss the findings with the Corporate Support Director if the evaluation identifies that additional resources are indeed required.

3.2.1.6 Portering/Patient Transfer

The IAC heard significant frustration regarding the VIP Portering system in use at the Hospital. The nurses provided many anecdotes regarding the lack of availability of Porters, difficulties with the software system used to make a portering request, lack of support for ‘stat calls’ to move patients to the OR, patient concerns at being left in the hall to wait for long periods etc. On the other hand, the Hospital provided data which indicated that on eight (8) randomly chosen days between mid February and mid April 2007, the response time to the 111 calls from Inpatient Surgery varied between 10 and 25 minutes, with an average of 15 minutes (not the 60 minutes referenced by the nurses). The Hospital also indicated that it is developing a guideline to clarify portering responsibilities after 1830 and on weekends, which is intended to lessen the need for 6th floor nurses to porter patients to/from the OR/PACU.

The IAC believes both that the ‘truth is likely somewhere in the middle’ and that ‘perception has become the believed reality’. The IAC understood the nurses’ frustration at being unable to effect change in a system that daily impacts their ability to provide quality care. The IAC also understood the Hospital’s efforts to improve a system-wide resource within fiscal constraint, and its perception that the electronic data suggests the system is not too bad. The IAC strongly recognizes the impact that lack of portering support has on nursing workload, and believes that the Clinical Director and Executive Vice President Surgical Services need to continue to monitor and advocate for an effective portering system that will support patient and equipment/supply movement throughout the building. The new “After 1830 Hours Guideline” will not be enough.

One element relating to movement of patients (though not directly to the VIP Portering system) is the frequent transfer of patients within the Units to accommodate admissions (reconfiguring patient placement to configure male and female rooms) and when patients are moved in and out of the OBS Unit as their condition improves/deteriorates. The inpatient staff (nurses and Clinical Assistant) are responsible for intra-unit transfer (Porters do not usually participate); consistent comments made throughout the Hearing convinced the IAC that intra-unit transfers occur frequently and are a significant workload issue.
The IAC explored whether the Hospital has given any formal consideration to implementing mixed sex rooms on the inpatient units. Mixed sex rooms are already in place in critical care units and Emergency Departments, and have been implemented on inpatient units in some hospitals. While recognizing that such a change in policy would require significant community consultation, the IAC encourages the Hospital to consider “small steps” towards implementation of a revised policy in the Inpatient Surgical Units, especially for patients whose expected length of stay will be less than two days. The IAC believes that any decrease in intra-unit transfers, especially those not related to patient condition, will be of benefit.

3.2.2 Workload Measurement

The IAC recognizes the many challenges that were inherent in the ‘traditional’ nursing workload measurement systems, and fully understands the Hospital’s decision to cease support of this initiative. However, some form of evaluative tool to measure workload and the impact of nursing resources on patient outcome would be beneficial to help ensure an appropriate novice-to-expert balancing of the RNs and appropriate skill mix between the RN and RPN staff. The CMG analysis and MOH-LTC “Hospital Functional Centre Indicator Tool” provide some information regarding complexity and costs of care, but do not explore the extent of or impact of nursing care on patient outcomes.

The IAC encourages the Hospital to consider becoming an active participant in the MOH-LTC Health Outcomes for Better Information and Care (HOBIC) initiative. Nurse-sensitive outcomes include functional status, therapeutic self-care, symptom status (pain, nausea, dyspnea, fatigue), patient safety outcomes (pressure ulcers and patient falls) and patient satisfaction with nursing care.\textsuperscript{17}

\textsuperscript{17} Nursing Sensitive Outcomes: State of the Science, Diane Doran (ed), Jones & Bartlett Inc, 2003

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3.3 Nursing Resources

3.3.1 Supplies and Equipment

The IAC was taken aback by the condition of the Clean Utility/Supply Rooms on both 6 South and 6 North. Both rooms appeared cluttered, with equipment and supplies in partially unpacked boxes on the floors, equipment on labeled shelves not corresponding to the labels etc. The Hospital has implemented a Late Career Initiative to organize the supply rooms, and is currently awaiting arrival of new shelves in order for the project to proceed. Both the Association and the Hospital positively referenced the recent purchase of new equipment, such as spot monitors for each team, dedicated isolation room equipment etc, and indicated that recent efforts to improve the process for repair of equipment (also a Late Career Initiative project) has resulted in improvement.

The IAC believes that responsibility for supplies, including linen, needs to be the responsibility of the appropriate Department ("Materials Management"). This Department needs to take steps to ensure that appropriate resources are available, and to explore, for example, the use of exchange carts, evaluation of par levels, and appropriate logistics for supply delivery. The Clinical Director is responsible for monitoring availability of supplies in relation to need, for identifying blocks impeding access to the appropriate required resources within a timely fashion, and for advocating for required change. Given the experiences to date, it appears that effecting the required changes will necessitate sustained advocacy.

The IAC recommends that

13. Accountability for management of the process of provision of supplies and equipment including linen, rest with the Corporate Services Department of Materials Management.

14. Notwithstanding Recommendation #12, the Clinical Director continue to formally monitor, and actively advocate for, appropriate supplies and linen to support patient care needs on 6 North and 6 South.

15. The Late Career Initiative projects (relating to reconfiguration of the Clean Utility Rooms) be completed by June 30, 2007.

The IAC recognizes the challenges associated with an older physical plant that was not built with technology, particularly computers, in mind. However, the IAC was concerned with the location of the computer terminals used by the RNs and RPNs for documentation. The majority of computers are located on desks in the hallway, which is of concern for two reasons: legislation regarding patient privacy requires the nurses to log in and out with each new entry (to ensure patient information is not evident on the screen) which is time-consuming, and documentation using a complex multi-screen software in a busy traffic area with multiple interruptions can lead to inadvertent error.

The IAC recommends that

16. The Hospital facilitate effective and focused on-line documentation by locating computer terminals used for patient documentation in a dedicated, quiet area that will afford minimal interruption, and by increasing the number of terminals to ensure availability for all nurses, particularly at the end of shift.
3.4 Nursing Leadership

Effective nursing leadership is a sentinel requirement for the support of professional practice within a quality practice environment. Effective strategic, operational and clinical leadership requires both the correct number and nature of leadership positions, and a participative approach on the part of the nursing leaders that supports and respects staff involvement in organizational and clinical decision-making.

Nursing leadership within the Inpatient Surgical Program occurs at three levels. The Vice President Nursing, as a member of the Senior Executive team, provides a strategic vision for professional practice and professional development within the hospital as a whole. The Clinical Director of the Inpatient Surgical Program bridges the Program’s operational/fiscal responsibilities with provision of clinical care to the Program’s patients, and ensures that the focus and scope of care provided fall within professional standards. The Resource Nurse provides day-to-day clinical coordination and support. Effective nursing leadership requires all three levels to function at a high level.

The Hospital expressed significant concern, in both its Pre-Hearing Brief and in discussion throughout the Hearing, that the Association made the decision to refer the Professional Workload Complaint to the IAC at exactly the time that a new Clinical Director was appointed to the Inpatient Surgical Program. The IAC believes that the apparent gap in effective nursing leadership at the Clinical Director level between 2004 and October 2006 was in fact a key reason for the decision to move to the Professional Workload Complaint process. It appeared to the IAC, from review of the substantial number of meeting minutes and from comments made at the Hearing, that the nurses did not feel the previous Clinical Director heard or supported their concerns, and that they felt he was unable to effect the changes necessary to improve the quality of their practice environment. Although the IAC appreciates the Hospital’s perspective on this issue, the IAC also recognizes that by the time the new Clinical Director was appointed in October, the decision to move forward to an IAC had been made.

The nurses view the appointment of the current Clinical Director in October 2006 to be positive, and their comments and behaviours throughout the Hearing indicated a respect for and desire to work effectively with her. Concurrently, the Clinical Director’s comments and demeanor demonstrated understanding of and support for the issues that the staff have identified, and a clear respect for the staff nurses themselves. The IAC was pleased to observe these dynamics, and believes that while it will take time for trust to develop, the future is positive.

3.4.1 Communication

The Inpatient Surgical Program has had several “groups” meeting regularly over the past several years to address issues of concern relating to the practice environment. These include the Surgical Program Unit Council, Surgical Program Staff Meetings, and the Surgical Program Core Group. In addition, professional workload issues have been discussed at Hospital-wide HAC meetings. However, while there have been many opportunities for dialogue, resolution to issues have not generally been achieved. Nurses’ comments at the Hearing included “discussion is not the problem – actual next step is the problem” and “everyone is listening, but no-one is hearing in terms of getting resolution”. The IAC believes that the scope and responsibility of each group needs to be clearly identified, to ensure that responsibility for decision-making falls to the appropriate group and that everyone is clear as to “who is on first for what”. In addition, the IAC believes that all issues or concerns should be directed through the appropriate communication / decision-making structures. Discussing workload concerns with patients is unprofessional.

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3.4.1.1 Intra-Program Communication and Decision-Making

The IAC believes that the Unit Council is a very effective mechanism for discussion and resolution of issues impacting practice and operations within 6 South and 6 North, but is not an effective mechanism to effect changes that have a financial or operational impact beyond the 6th floor. As a shared governance tool, the Unit Council has the autonomy to make decisions within the operations of the two Units, but does not have the authority or scope to make decisions that involve other groups, other professions or other Departments. Trying to do so only leads to circular discussions and frustration.

Therefore, for example, decisions regarding the mechanism of how shift report will be provided or how the RN-RPN teams will be configured are within the scope of the Unit Council. Decisions impacting other Departments, such as the ongoing challenge with linen quotas, are not within the authority of the Unit Council to make.

The Unit Council Terms of Reference\(^\text{18}\) indicate two purposes:

- To develop, implement, monitor and evaluate all aspects of service provision on the Inpatient Surgical Unit in order to achieve hospital vision and mission
- To work collectively on decision-making related to practice and procedures that enhance the quality of patient care, work environment, and relationships among the staff.

The IAC believes that the Terms of Reference need to be revised to narrow the scope to the "aspects of service provision" that are within the authority of the members on the Unit Council to control\(^\text{19}\). The IAC applauds the tenacity with which the RNs (and RPNs) on the Inpatient Surgical Units have 'stuck with' the Unit Council despite frustration and disappointment, and encourages them to continue to move forward to address issues that are within their authority to control. The IAC believes that the current model of co-chairs (one staff member, one management member) is effective and should be continued.

The IAC recommends that

17. The Inpatient Surgical Program Unit Council be the mechanism for discussion of and resolution of operational and practice issues/opportunities occurring within the Program.
   a. The Terms of Reference for the Unit Council be revised to reflect the scope of its responsibilities.
   b. The current practice of staff and management co-chairs continue.
   c. The minutes of the Unit Council meetings document discussion of issues, actions decided upon, timelines, and accountability for action/follow-up.
   d. The agenda of the Unit Council meetings include a 'business arising' section to ensure previously discussed items are brought forward at the next meeting to document progress/resolution.

The IAC believes that the Quarterly Staff Meeting is an effective mechanism for the distribution of information, but that it is not a decision-making group. The decision-making group regarding intra-program issues is the Unit Council, and regarding inter-program/inter-Department issues is the Core Group.

\(^{18}\) Document dated February 9, 2005

\(^{19}\) The remainder of the February 9, 2005 Terms of Reference are clear and well written.

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The Terms of Reference for the Staff Meeting need to indicate that the Staff Meeting is intended to provide a forum for the regular provision of information to staff and that it is chaired by the Clinical Director. The Quarterly (or more often) Staff Meetings enable the Clinical Director to provide updates regarding activities and initiatives within the Hospital as a whole (including those outside of the Surgical Program as well as within). If issues requiring discussion/debate/decision are identified during the Staff Meeting, they should be referred to the appropriate decision making group (intra-program: Unit Council; inter-program: Core Group) for resolution.

The IAC recommends that

18. The Quarterly Staff Meeting Terms of Reference be developed to indicate its scope as an information sharing, not decision-making group.
   a. Staff meetings continue to be held on a regular basis (quarterly or more often), chaired by the Clinical Director.
   b. Minutes of Staff Meetings be distributed to all staff members in a timely fashion.

3.4.1.2 Inter-Program Communication and Decision-Making

The Core Group was initiated in January 2006. Membership included middle (Clinical Director) and senior (Executive Vice President, Surgical Services) leaders, the Bargaining Unit President and Program staff. Because of the range of membership, the Group was able to make decisions that impacted beyond the scope of the Inpatient Surgical Units themselves.

The IAC was impressed with the efforts of the Core Group during the six months it met between January and June 2006. Although the nurses did not feel that their concerns would/could be totally resolved through this mechanism, it did enable some effective changes (e.g. partial resolution of the linen quota issue, development and implementation of a new master schedule).

The IAC believes that the Core Group should continue to function, for at least the foreseeable future, in order to enable discussion of issues that impact the 6th floor but require the involvement of other Departments/groups to resolve. Examples of such issues include the ongoing need for discussion/decision regarding the operations of the new StepDown Unit on the 2nd floor, and the need for discussion of the IAC recommendations and determination of follow-up. Both of these issues will require authority for decision-making beyond the Inpatient Surgical Program.

The IAC recommends that

19. The Core Group be reconstituted, with membership to include the Vice President Surgical Services, Vice President Nursing, Clinical Director Inpatient Surgical Program, Local 139 Bargaining Unit President, and 6th floor RN and RPN staff.
   a. The Core Group meet on a quarterly basis and ad hoc, as issues arise.
   b. Minutes of the Core Group document discussion of issues, actions decided upon, timelines, and accountability for action/follow-up
   c. The agenda for Core Group meetings include a ‘business arising’ section to ensure previously discussed items are brought forward at the next meeting to document progress/resolution.
The Hospital Association Committee (HAC) is the forum for discussion of Professional Responsibility Workload (PRW) forms. The Unit Council is not the appropriate venue for this discussion. The intent of, and the actions expected with each Step in the Professional Responsibility Workload process, as identified in Article 8.01 of the Collective Agreement, need to be mutually understood by both the Hospital and the Association.
PART IV: SUMMARY AND CONCLUSION

4.1 Summary

The IAC was requested to address the issue of whether the Registered Nurses on the Inpatient Surgical Unit at the K-W Health Centre Site of the Grand River Hospital are being requested to perform more work than is consistent with proper patient care.

Through a comprehensive process involving written and oral submissions and direct discussion at a 2-1/2 day Hearing, the IAC concluded that the provision of care to the surgical patients on 6 North and 6 South at a 1:5 nurse:patient ratio is appropriate. The IAC further concluded that the RN/RPN skill mix, and the manner of patient assignment through consistent RN/RPN teams, is appropriate in the circumstances.

The IAC concluded, however, that maintenance of the staffing required to provide a consistent 1:5 nurse:patient ratio is causing inappropriate levels of stress on the full-time and regular part-time nurses, who are regularly requested/required to work “overtime” premium shifts to cover relief needs. Although recent changes have been initiated by the Hospital to increase the availability of part-time, casual and Float Pool nurses to cover relief needs, the IAC concluded that additional focused monitoring and evaluation of the balance of resources is required, and that this monitoring will likely demonstrate the need for additional relief staff. As well, the IAC believes that the transfer of the OBS Unit may result in increased patient acuity/care needs on 6 North and 6 South, which will need to be monitored very carefully to ensure that quality care can continue to be provided within a 1:5 nurse:patient ratio.

The IAC identified that effective maintenance of the 1:5 nurse:patient ratio requires a number of additional supports, including on-site clinical leadership, para-professional and multi-professional support staff, and appropriate supplies and equipment. The IAC believes that funded clinical leadership coverage is required on both 6 North and 6 South Monday to Friday 0700 – 2300, on 6 South on Saturday 0700 – 1500 and on 6 North on Saturday 0700 – 1900 and on Sunday 0700 – 1500, in order to ensure that the RNs and RPNs providing direct care are able to do so at a 1:5 nurse:patient ratio. In addition, the IAC believes that careful monitoring and evaluation of the Clinical Assistant role is required, to ensure that the role is effectively maximized on both 6 North and 6 South. The Hospital is aware of the vital need to ensure that corporate supports, particularly portering and housekeeping, are effectively available to support quality nursing care.

Finally, the IAC identified that although communication within and among Surgical Program, Hospital Management and Association Executive staff is voluminous, clear delineation of accountability/ scope of authority for decision-making regarding intra-Program and inter-Program issues is required to enable effective resolutions to issues to be achieved.
4.2 Summary of Recommendations

The IAC identified 19 recommendations relating to staffing, resource supports and communication.

Staffing:

1. The Clinical Director monitor the balance between relief staff availability and relief requirements for six months (June 1, 2007 to November 30, 2007) to identify the number of shifts that are replaced by
   (a) Surgical Program part-time (within committed hours) and casual staff,
   (b) Float Pool staff, and
   (c) full-time and part-time (outside of committed hours) on a premium basis.

2. The Clinical Director work with the Recruitment Coordinator to hire additional staff (casual and full-time/regular part-time term (time-limited) positions) to ensure that full-time and part-time (outside of committed hours) will never be required to work overtime (premium time) to meet short-notice relief requirements.

3. The Clinical Director evaluate the new Master Rotation for the period April 6, 2007 to September 30, 2007 (6 months) to determine
   - the number of shifts where the schedule as defined varies (because RN is replaced with RPN or vice versa, or because short-notice relief needs are not met)
   - the number of shifts RNs/RPNs called in sick
   - the number of overtime (premium pay) shifts
   - the balance of novice-to-expert resources within each 24 hour period, and within each Unit
   - the number of times short-term relief needs could not be met by part-time/casual staff and Float Pool
   - qualitative level of satisfaction of RNs and RPNs

   and, based on the above evaluation, work with the Unit Council to collaboratively identify and implement any required changes.

4. The Clinical Director monitor the impact of the transfer of the OBS Unit on the acuity/care needs/workload on the 6th floor and work with the Vice President Nursing and Chief of Surgery to ensure that the criteria for transfer into the Stepdown Unit do not preclude nurses’ autonomy to transfer patients who require enhanced assessment or complex interventions into the Unit.

5. The Resource Nurse (or Charge Nurse on Nights/Weekends) have the authority to call staff for short-term replacement / patient acuity needs independently, in accordance with the Central and Local Collective Agreements regarding seniority.

Resource Supports:

6. The hours of Resource Nurse coverage be increased by 3.75 hours Monday through Friday to cover Days (0700 – 1500) and Evenings (1500 – 2300) on 6 North and 6 South.
7. The Resource Nurse schedule be determined mutually by the Resource Nurses and the Clinical Director, with the caveat that the schedules maintain five-day continuity.

8. The revised Resource Nurse schedule be evaluated, using mutually determined criteria, by the Unit Council and Clinical Director, in January 2008.

9. A Charge Nurse position be funded for 0700 – 1500 hours on Saturday on 6 South. The Charge Nurse will not carry a patient assignment.

10. A Charge Nurse position be funded for 0700 – 1900 hours on Saturday, and for 0700 – 1500 hours on Sunday on 6 North. The Charge Nurse will not carry a patient assignment.

11. The Clinical Director work with the CAW to modify the job expectations for the Clinical Assistant position on Inpatient Surgery to clarify that the Clinical Assistant receives direction regarding patient care activities from the Registered Nurses and Registered Practical Nurses, but does not receive direction from the Physiotherapist.

12. The Clinical Director monitor the ongoing implementation of the Clinical Assistant role to ensure that the role is effectively maximized on both 6 North and 6 South.

13. Accountability for management of the process of provision of supplies and equipment including linen, rest with the Corporate Services Department of Materials Management.

14. Notwithstanding Recommendation #12, the Clinical Director continue to formally monitor, and actively advocate for, appropriate supplies and linen to support patient care needs on 6 North and 6 South.

15. The Late Career Initiative projects (relating to reconfiguration of the Clean Utility Rooms) be completed by June 30, 2007.

16. The Hospital facilitate effective and focused on-line documentation by locating computer terminals used for patient documentation in a dedicated, quiet area that will afford minimal interruption, and by increasing the number of terminals to ensure availability for all nurses, particularly at the end of shift.

Communication:

17. The Inpatient Surgical Program Unit Council be the mechanism for discussion of and resolution of operational and practice issues/opportunities occurring within the Program.  
   a) The Terms of Reference for the Unit Council be revised to reflect the scope of its responsibilities.  
   b) The current practice of staff and management co-chairs continue.  
   c) The minutes of the Unit Council meetings document discussion of issues, actions decided upon, timelines and accountability for action/follow-up.  
   d) The agenda of the Unit Council meetings include a ‘business arising’ section to ensure previously discussed items are brought forward at the next meeting to document progress/resolution.

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18. The Quarterly Staff Meeting Terms of Reference be developed to indicate its scope as an information sharing, not decision-making group.
   a) Staff meetings continue to be held on a regular basis (quarterly or more often), chaired by the Clinical Director.
   b) Minutes of Staff Meetings be distributed to all staff members in a timely fashion.

19. The Core Group be reconstituted, with membership to include the Vice President Surgical Services, Vice President Nursing, Clinical Director Inpatient Surgical Program, Local 139 Bargaining Unit President, and 6th floor RN and RPN staff.
   a) The Core Group meet on a quarterly basis, and ad hoc as issues arise.
   b) Minutes of the Core Group document discussion of issues, actions decided upon, timelines and accountability for action/follow-up
   c) The agenda for Core Group meetings include a ‘business arising’ section to ensure previously discussed items are brought forward at the next meeting to document progress/resolution.
4.3 Conclusion

The IAC appreciates the efforts that the Association, the Hospital, and the individual Registered Nurses put forth in the preparation of their written submissions, the development of their oral presentations and responses, and in their thoughtful and considered discussion at the Hearing. The IAC also appreciates the significant effort made by both the Hospital and the Registered Nurses, to enable as many Registered Nurses as possible to attend and participate in the Hearing.

The IAC respects the efforts that all parties have made to identify and address issues, and recognizes the desire of both the Association, representing the Registered Nurses, and the Hospital to move forward to achieve mutually agreeable solutions. At the same time, the IAC respects the frustration that both parties have experienced when resolutions to issues have not been forthcoming.

The IAC believes that the Hospital, the Association and the Registered Nurses have the ability and the desire to move forward constructively. While history and past experience are useful to understand the context of the present situation, successful progress will depend on a willingness, on everyone's part, to look to the future to achieve solutions. The IAC hopes that the recommendations will provide a basis for discussion and mutual decision to achieve the outcome desired by all, that of quality patient care provided by nurses working in a supportive and effective practice environment.
March 20, 2007

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

Dear Ms. Cardiff,

Re: Grand River Hospital - Surgical Unit (6 North and 6 South): Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – OUR FILE # 261595

In accordance with Article 8.01 of the collective agreement between the parties, the Hospital Association Committee met to consider the Professional Responsibility Workload Forms and ongoing practice concerns and subsequently, many remain unresolved.

With this letter ONA is referring the unresolved concerns specified below to the Independent Assessment Committee for review and recommendations:

1. Nursing workload – inappropriate patient assignment; inadequate staffing base of full-time and part-time staff; unfilled vacancies on the schedule; high overtime; high sick time; no sick call replacement;

2. Nursing resources – low or minimal patient supplies; lack of equipment; minimal support staff for access;

3. Nursing leadership – retention and recruitment problems resulting in inadequate staffing (25 RNs and 12 RPNs leaving the unit); poor communications with nursing staff; no follow through of unit plans with organizational direction; unhealthy work environment.

ONA respectfully submits this Professional Responsibility Complaint to the IAC. The hearing dates have been set up for April 17, 18 and 19, 2007. ONA will therefore provide the IAC with our submission by March 23, 2007 as required by you to give you adequate review time.

We thank you for your assistance in this matter.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic
LRO, Professional Practice Specialist

mm/al
Re: Grand River Hospital - Surgical Unit (6 North and 6 South): PRC – Proceeding to an Independent Assessment Committee – OUR FILE # 261595

C: Trudy Molke, ONA Nominee (by email)
   Beatrice Mudge, Employer Nominee (by email)
   Elaine Reed, Local Coordinator, ONA Local 139
   Kris Bailey, Chair, Grand River Hospital Board of Directors
   Patrick Gaskin, Executive Vice President
   Gloria Whitson-Shea, Vice President and Chief Nursing Officer
   Heather Eddy, President, Human Resources
   Kathi Wilkins Snell, Labour Relations Officer, ONA
   Sam Mandelbaum, Director, Hospital Employee Relation Services, OHA
February 19, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms Mariana Markovic
LRO, Professional Practice Specialist
Ontario Nurses’ Association
85 Grenville Street, Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms Markovic:

Re: Grand River Hospital, Kitchener and Ontario Nurses’ Association Professional Responsibility Complaint – Independent Assessment Committee Hearing

I am writing to confirm that the Independent Assessment Committee (IAC) Hearing regarding the above issue will be held at the Delta Hotel, 105 King Street East, Kitchener, on Tuesday April 17th, Wednesday April 18th and Thursday April 19th, 2007, as per the attached agenda.

On the morning of Tuesday April 17th, the IAC will meet briefly prior to touring the Surgical Units. The Tour of the Surgical Units will begin at 10.00 hours. I am requesting that the Ontario Nurses’ Association (ONA) work with the Grand River Hospital to coordinate the arrangements for the tour, including determination of

- how many ONA and Grand River representatives will accompany us on the tour, and who these individuals will be,
- who will lead the tour through the Surgical Units,
- what the schedule of the tour will be, and
- where the IAC Committee members should arrive to begin the tour.

Please ensure that I receive the above information by Monday April 2nd, 2007.

The Hearing will begin at 1300 hours on Tuesday April 17th, 2007. Each of the Ontario Nurses’ Association and the Grand River Hospital will have one and one half (1-1/2) hours to present their submission. I have not yet arranged for any AV equipment to be available; if you plan to provide a power-point presentation, please let me know by April 2nd, and I will arrange for an LCD projector to be available. 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 April 18th with the Reply from the Grand River Hospital, followed by the Reply from the Ontario Nurses’ Association. Each party will have one (1) hour to present their Reply. 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 then meet, to determine areas requiring further clarification.

The Hearing will recommence on the morning of Thursday April 19th with Questions to both parties by the Independent Assessment Committee. The Hearing is currently scheduled to close
at 1200 hours on Thursday April 19th; if additional time is required, arrangements will be made for continuation of the Hearing at a later date, at that time.

The Hearing will be held in the Delta Kitchener Trillium Suite. Refreshments will be available in morning and afternoon, but lunch will not be provided. The ONA and the Hospital will each have a caucus room available for the full three days of the Hearing; the specific rooms will be assigned on Tuesday April 17th. Each caucus room will be equipped with a telephone and configured in a boardroom style for 10 people. Refreshments (coffee and tea) will be available.

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC is requesting the Ontario Nurses' Association and the Grand River Hospital to provide individual, independent, written submissions to the IAC by close of business day (1600 hours) on Friday March 23, 2007. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will distribute the submissions with attachments by courier on Monday March 26th, 2007 as follows:

- one (1) copy of the Grand River Hospital submission and one (1) copy of the ONA submission to Beatrice Mudge (Hospital Nominee);
- one (1) copy of the Grand River Hospital submission and one (1) copy of the ONA submission to Trudy Molke (ONA Nominee);
- two (2) copies of the Grand River Hospital submission to the ONA (attention Mariana Markovic);
- two (2) copies of the ONA submission to the Grand River Hospital (attention Patrick Gaskin);
- I will retain one (1) copy of each submission.

In the event that either party wishes to provide supplemental information after March 23, 2007, supplemental information will be accepted to the close of business (1600 hours) on Monday April 2, 2007, with evidence of approval from the other party. Supplemental information will not be accepted after this date. The IAC will be meeting to review the submissions in detail, in advance of the Hearing, the week of April 2nd.

Finally, please forward the name and position/title of the individuals who will be attending the Hearing as participants to me by Friday April 13th. The IAC anticipates that additional individuals may attend the Hearing for one or more days as observers.

If you have any questions, please do not hesitate to contact me by phone at 613-260-2415 or by email at jcardiff@cheo.on.ca.

Sincerely

Jean Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
    Beatrice Mudge, Hospital Nominee
    Patrick Gaskin, Acting President and CEO, Grand River Hospital
February 19, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Mr Patrick Gaskin
Acting President and CEO
Grand River Hospital
855 King Street West
Kitchener, Ontario
N2G 2M7

Dear Mr Gaskin:

Re: Grand River Hospital, Kitchener and Ontario Nurses' Association Professional Responsibility Complaint – Independent Assessment Committee Hearing

I am writing to confirm that the Independent Assessment Committee (IAC) Hearing regarding the above issue will be held at the Delta Hotel, 105 King Street East, Kitchener, on Tuesday April 17th, Wednesday April 18th and Thursday April 19th, 2007, as per the attached agenda.

On the morning of Tuesday April 17th, the IAC will meet briefly prior to touring the Surgical Units. The Tour of the Surgical Units will begin at 10:00 hours. I am requesting that the Grand River Hospital work with the Ontario Nurses' Association (ONA) to coordinate the arrangements for the tour, including determination of

- how many Grand River and ONA representatives will accompany us on the tour, and who these individuals will be,
- who will lead the tour through the Surgical Units,
- what the schedule of the tour will be, and
- where the IAC Committee members should arrive to begin the tour.

Please ensure that I receive the above information by Monday April 2nd, 2007.

The Hearing will begin at 1300 hours on Tuesday April 17th, 2007. Each of the Ontario Nurses' Association and the Grand River Hospital will have one and one half (1-1/2) hours to present their submission. I have not yet arranged for any AV equipment to be available; if you plan to provide a power-point presentation, please let me know by April 2nd, and I will arrange for an LCD projector to be available. 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 April 18th with the Reply from the Grand River Hospital, followed by the Reply from the Ontario Nurses' Association. Each party will have one (1) hour to present their Reply. 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 then meet, to determine areas requiring further clarification.

The Hearing will recommence on the morning of Thursday April 19th with Questions to both parties by the Independent Assessment Committee. The Hearing is currently scheduled to close
at 1200 hours on Thursday April 19th; if additional time is required, arrangements will be made for continuation of the Hearing at a later date, at that time.

The Hearing will be held in the Delta Kitchener Trillium Suite. Refreshments will be available in morning and afternoon, but lunch will not be provided. The Hospital and the ONA will each have a caucus room available for the full three days of the Hearing; the specific rooms will be assigned on Tuesday April 17th. Each caucus room will be equipped with a telephone and configured in a boardroom style for 10 people. Refreshments (coffee and tea) will be available.

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC is requesting the Grand River Hospital and the Ontario Nurses’ Association to provide individual, independent, written submissions to the IAC by close of business day (1600 hours) on Friday March 23, 2007. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will distribute the submissions with attachments by courier on Monday March 26th, 2007 as follows:

• one (1) copy of the Grand River Hospital submission and one (1) copy of the ONA submission to Beatrice Mudge (Hospital Nominee);
• one (1) copy of the Grand River Hospital submission and one (1) copy of the ONA submission to Trudy Molke (ONA Nominee);
• two (2) copies of the Grand River Hospital submission to the ONA (attention Mariana Markovic);
• two (2) copies of the ONA submission to the Grand River Hospital (attention Patrick Gaskin);
• I will retain one (1) copy of each submission.

In the event that either party wishes to provide supplemental information after March 23, 2007, supplemental information will be accepted to the close of business (1600 hours) on Monday April 2, 2007, with evidence of approval from the other party. Supplemental information will not be accepted after this date. The IAC will be meeting to review the submissions in detail, in advance of the Hearing, the week of April 2nd.

Finally, please forward the name and position/title of the individuals who will be attending the Hearing as participants to me by Friday April 13th. The IAC anticipates that additional individuals may attend the Hearing for one or more days as observers.

If you have any questions, please do not hesitate to contact me by phone at 613-260-2415 or by email at jcardiff@cheo.on.ca.

Sincerely

Joan Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
    Beatrice Mudge, Hospital Nominee
    Mariana Markovic, Professional Practice Specialist, ONA
March 26, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms Mariana Markovic
LRO, Professional Practice Specialist
Ontario Nurses’ Association
85 Grenville Street, Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms Markovic:

Re: Grand River Hospital, Kitchener and Ontario Nurses’ Association Professional Responsibility Complaint: Surgical Unit (6 North and 6 South) – Independent Assessment Committee Hearing

Thank you for forwarding the Ontario Nurses’ Association’s Brief for the above Independent Assessment Committee Hearing, which I received as requested on Friday March 23, 2007.

In preparation for the Independent Assessment Committee Hearing scheduled for April 17 – 19, 2007 at the Delta Hotel in Kitchener, enclosed please find two copies of the Grand River Hospital Brief.

Two copies of the Ontario Nurses’ Association Brief and Supporting Documents Binder will be couriered today to the Grand River Hospital, care of Mr. Patrick Gaskin.

One copy of each of the Grand River Hospital Brief and the Ontario Nurses’ Association Brief and Supporting Documents binder, as well as one copy of the Collective Agreement, will be couriered today to Trudy Molke, ONA Nominee, and Beatrice Mudge, Hospital Nominee.

If the Ontario Nurses’ Association wishes to submit any additional information prior to the Hearing, please contact me. I will confirm agreement with the Grand River Hospital, and will then arrange for distribution of the additional information in the same manner as above. Please note that additional information must be received in hard copy to my address by close of business day on Monday April 2, 2007.

Thank you for forwarding the names of the Registered Nurses who will be attending the Hearing and who will join the Committee on the Tour of the Surgical Units on the morning of Tuesday April 17th. At your convenience, please confirm whether the Association will require AV support for your Submission presentation.
The Independent Assessment Committee is looking forward to meeting the members of your team on April 17, 2007. In the meantime, please contact me if you have any questions. I can be reached by phone at (613) 260-2415 or by email at jcardiff@co.ont.ca.

Sincerely

[Signature]

Joan Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
    Beatrice Mudge, Hospital Nominee
    Patrick Gaskin, Grand River Hospital
March 26, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Mr Patrick Gaskin
Acting President and CEO
Grand River Hospital
855 King Street West
Kitchener, Ontario
N2G 2M7

Dear Mr Gaskin:

Re: Grand River Hospital, Kitchener and Ontario Nurses’ Association Professional Responsibility Complaint: Surgical Unit (6 North and 6 South) – Independent Assessment Committee Hearing

Thank you for forwarding the Grand River Hospital’s Brief for the above Independent Assessment Committee Hearing, which I received as requested on Friday March 23, 2007.

In preparation for the Independent Assessment Committee Hearing scheduled for April 17 – 19, 2007 at the Delta Hotel in Kitchener, enclosed please find two copies of the Ontario Nurses’ Association Brief and Supporting Document binder.

Two copies of the Grand River Hospital Submission will be couriered today to the Ontario Nurses’ Association, care of Ms. Mariana Markovic.

One copy of each of the Grand River Hospital Submission and the Ontario Nurses’ Association Submission and Supporting Documents binder, as well as one copy of the Collective Agreement, will be couriered today to Trudy Molke, ONA Nominee, and Beatrice Mudge, Hospital Nominee.

If the Grand River Hospital wishes to submit any additional information prior to the Hearing, please contact me. I will confirm agreement with the Ontario Nurses’ Association, and will then arrange for distribution of the additional information in the same manner as above. Please note that additional information must be received in hard copy to my address by close of business day on Monday April 2, 2007.

At your convenience, please confirm the name and position/title of the individuals from the Hospital who will be attending the Hearing. Please also confirm the logistics for the Tour of the Surgical Units scheduled for the morning of Tuesday April 17, 2007, specifically where the Independent Assessment Committee should arrive at 10:00 hours. Finally, please confirm whether the Hospital will require AV support for your Submission presentation.
The Independent Assessment Committee is looking forward to meeting the members of your team on April 17, 2007. In the meantime, please contact me if you have any questions. I can be reached by phone at (613) 260-2415 or by email at jecardiff@chige.on.ca.

Sincerely

[Signature]

Jean Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
   Beatrice Mudge, Hospital Nominee
   Mariana Markovic, Ontario Nurses’ Association
April 3, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Ms Mariana Markovic
LRO, Professional Practice Specialist
Ontario Nurses’ Association
85 Grenville Street, Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms Markovic:

Re: Grand River Hospital, Kitchener and Ontario Nurses’ Association Professional Responsibility Complaint: Surgical Unit (6 Noth and 6 South) – Independent Assessment Committee Hearing

Thank you for forwarding additional information to complement the Ontario Nurses’ Association Submission regarding the above Independent Assessment Committee (IAC) Hearing. I will forward this information to the Grand River Hospital and the IAC Committee members by courier tomorrow.

The IAC also received additional information today from the Grand River Hospital, two copies of which are attached.

Thank you for confirming your AV requirements for presentations at the Hearing.

The IAC will look forward to meeting you at the Main Reception of the Hospital at 10:00 hours on April 17, 2007 at the commencement of the Tour of the Surgical Units.

Sincerely

Joan Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
    Beatrice Mudge, Hospital Nominee
    Patrick Gaskin, Grand River Hospital
April 3, 2007

306 Freedom Private
Ottawa, Ontario
K1G 6W4

Mr Patrick Gaskin
Executive Vice President
Grand River Hospital
855 King Street West
Kitchener, Ontario
N2G 2M7

Dear Mr. Gaskin:

Re: Grand River Hospital, Kitchener and Ontario Nurses’ Association Professional Responsibility Complaint: Surgical Unit (6 North and 6 South) – Independent Assessment Committee Hearing

Thank you for forwarding additional information to complement the Grand River Hospital Submission regarding the above Independent Assessment Committee (IAC) Hearing. I will forward this information to the Ontario Nurses’ Association and the IAC Committee members by courier tomorrow.

The IAC also received additional information today from the Ontario Nurses’ Association, two copies of which are attached.

Thank you for confirming the specifics of the Tour of the Surgical Units on the morning of April 17th. We will look forward to meeting you at the Main Reception of the Hospital at 10:00 hours that morning.

Sincerely

Joan Edwards Cardiff
Chair, Independent Assessment Committee

cc. Trudy Molke, ONA Nominee
Beatrice Mudge, Hospital Nominee
Mariana Markovic, Ontario Nurses’ Association
Good morning Patrick.

The IAC met yesterday to discuss the recommendations we will be submitting. In the course of our day-long discussion, we determined that we need clarification on a few items on which we realized we are not yet clear.

Our questions are the following:

1. What are the room configurations (i.e. the number of private, semiprivate and ward rooms) on each of 6 South and 6 North? We do not remember, and we can’t figure it out from the floor layout diagram.

2. What is the Clinical pharmacist coverage on the 6th floor?

   - Do each of 6 North and 6 South have a defined Clinical Pharmacist (or do they share with each other, or with other units?) What are the hours of work of the Clinical Pharmacist, and what exactly is their role?
   - We recall some discussion regarding general Pharmacist shortages in the hospital; how often are the Clinical Pharmacists "pulled back" to the pharmacy (i.e. pulled off the floor to work in the main pharmacy?).

3. What is the average daily patient turnover on 6 South and on 6 North?

   - That is, how many admissions, discharges, and intra-hospital transfers (e.g. to/from the 6th floor to another unit/location in the hospital) occur daily? Please provide data for January, February and March 2007, if this is possible.
   - We would also like to know (though we recognize this may not be possible to obtain) the average number of intra-unit transfers per day (that is, the number of times patients are moved within the unit to accommodate male / female rooms etc) on each of 6 South and 6 North.

4. Does the Clinical Director (Brenda) have responsibility for any other Programs/units within the hospital, or is the Inpatient Surgical Program on the 6th floor her only responsibility? We understand that when she first moved to Inpatient Surgery in the fall, she continued to carry responsibilities for Ambulatory Care; is this still the case?

5. What is the Operating Room schedule. Specifically

   - how many rooms are booked on days Monday to Friday
   - how many rooms are booked on evenings Monday to Friday (we think two...??)
   - how many unanticipated/urgent/emergent ORs are completed on an average weekend (please provide data for January through March if this is possible)
   - what days do the orthopedic surgeons, the gynae surgeons and the general surgeons have booked time?

6. Please forward the current role description for the Clinical Assistant. Are they a member of a bargaining unit, and if so, is their role specifically defined within the Collective Agreement, or are revision to their responsibilities possible?

In the interests of time, please respond using "reply all" to the above questions, so that the IAC Committee members and the Association will receive the information at the same time as myself. Please provide the
information as it is available (i.e. if some can be provided today, please do so; if some cannot be provided until later in the week, please send it as soon as it is available).

We understand that we have again asked for a substantial amount of information, and appreciate the time and effort that will go into providing it.

Thanks very much, and please email me (also using "reply all") if you have any questions or require clarification on any of these six items.

Joan Cardiff
Independent Assessment Committee

Ontario Nurses’ Association
and
Grand River Hospital, Kitchener

Professional Responsibility Complaint

Tuesday April 17, 2007

Trillium Suite
Delta Hotel
105 King Street East, Kitchener

08:30 – 09:30  Independent Assessment Committee Meeting
09:30 – 10:00  IAC Travel to Grand River Hospital
10:00 – 12:00  Tour of Surgical Units (6 North and 6 South)

13:00 – 13:15  Commencement of Hearing
  • Hearing Introduction and Review of Proceedings
13:15 – 14:45  • Ontario Nurses Association Submission Presentation
  • Response to questions of clarification by
    • Independent Assessment Committee
    • Grand River Hospital

14:45 – 15:15  Break

15:15 – 16:45  • Grand River Hospital Submission Presentation
  • Response to questions of clarification by
    • Independent Assessment Committee
    • Ontario Nurses’ Association

16:45 – 17:00  • Adjournment of Hearing and Review of Process for April 18, 2007
Independent Assessment Committee

Ontario Nurses' Association
and
Grand River Hospital, Kitchener

Professional Responsibility Complaint

Wednesday April 18, 2007

Trillium Suite
Delta Hotel
105 King Street East, Kitchener

0800 – 0900  Independent Assessment Committee Meeting

0900 – 12:00  Continuation of Hearing

• Grand River Hospital Reply to Ontario Nurses' Association Submission
  • Response to questions of clarification by
  • Independent Assessment Committee
  • Ontario Nurses’ Association
  • Discussion

Break

• Ontario Nurses’ Association Reply to Grand River Hospital Submission
  • Response to questions of clarification by
  • Independent Assessment Committee
  • Grand River Hospital
  • Discussion

12:00 – 13:00  Lunch Break

13:00 – 15:45  Continuation of Hearing as above (time as required)

15:45 – 16:00  • Adjournment of Hearing and Review of Process for April 19, 2007

16:00 – 20:00  Independent Assessment Committee Meeting
Independent Assessment Committee

Ontario Nurses' Association
and
Grand River Hospital, Kitchener

Professional Responsibility Complaint

Thursday April 19, 2007

Trillium Suite
Delta Hotel
105 King Street East, Kitchener

08:30 – 11:30  Continuation of Hearing
* Questions to both Parties by Independent Assessment Committee

11:30 – 12:00  * IAC Summary and Identification of Next Steps
Closure of Hearing

12:00 – 15:00  Independent Assessment Committee Meeting
Appendix VII

April 17, 2007

Hearing Participants:

For the Hospital: Connie Coggan, Communications Coordinator
Heather Eddy, Acting Human Resources Director
Patrick Gaskin, Acting President and Chief Executive Officer
Brenda Leis, Clinical Director, Inpatient Surgical Program
Rusty McLay, Hicks Morley, Counsel
Gloria Whitson-Shea, Vice President and Chief Nursing Officer

For the Association: Anne Good, Registered Nurse, 6 North, 6 South, Pain Program
Janet Hintermayer, Registered Nurse, 6 North
Jorja Lamb, Resource Nurse, 6 North
Mariana Markovic, Professional Practice Specialist, ONA
Edie McMyler, Registered Nurse 6 North
Elaine Reed, Bargaining Unit President, Local 139
Shalom Schachter, LTC Regulation/HDLAA Lead, ONA
Kathi Wilkins-Snell, Servicing Labour Relations Office, ONA
Shannon Wright, Registered Nurse, 6 South

Observers:

For the Association: Glenna Burkholder, Registered Nurse, 6 North
Bernadette Gordon, Resource Nurse, 6 North
Rozanna Haynes, Professional Practice Specialist, ONA
Marilyn Scharoun, Registered Nurse, 6 North

Wednesday April 18, 2007

Hearing Participants:

For the Hospital: Connie Coggan, Communications Coordinator
Heather Eddy, Acting Human Resources Director
Patrick Gaskin, Acting President and Chief Executive Officer
Brenda Leis, Clinical Director, Inpatient Surgical Program
Rusty McLay, Hicks Morley, Counsel
Gloria Whitson-Shea, Vice President and Chief Nursing Officer

For the Association: Rozanna Haynes, Professional Practice Specialist, ONA
Janet Hintermayer, Registered Nurse, 6 North
Jorja Lamb, Resource Nurse, 6 North
Mariana Markovic, Professional Practice Specialist, ONA
Edie McMyler, Registered Nurse, 6 North
Elaine Reed, Bargaining Unit President, Local 139
Kathi Wilkins-Snell, Servicing Labour Relations Officer, ONA
Shannon Wright, Registered Nurse, 6 South
Observers:

For the Association: Glenna Burkholder, Registered Nurse, 6 North
Salima Maurani, Registered Nurse, 6 North
Marilyn Scharoun, Registered Nurse, 6 North

Thursday April 19, 2007

Hearing Participants:

For the Hospital: Heather Eddy, Acting Human Resources Director
Patrick Gaskin, Acting President and Chief Executive Officer
Brenda Leis, Clinical Director, Inpatient Surgical Program
Gloria Whitson-Shea, Vice President and Chief Nursing Officer

For the Association: Janet Hintermayer, Registered Nurse, 6 North
Jorja Lamb, Resource Nurse, 6 North
Mariana Markovic, Professional Practice Specialist, ONA
Edie McMyler, Registered Nurse, 6 North
Elaine Reed, Bargaining Unit President, Local 139
Shannon Wright, Registered Nurse, 6 South

Observers:

For the Association: Rozanna Haynes, Professional Practice Specialist, ONA
Marguerite Polischuk, Registered Nurse, 6 South
Marilyn Scharoun, Registered Nurse, 6 North
Kathi Wilkins-Snell, Servicing Labour Relations Officer, ONA
Appendix VIII

Ontario Nurses’ Association Recommendations

Inability of Registered Nurses to meet their professional standards:

1. That staffing quotas and patient assignments ensure time for the nursing process.

2. That staffing quotas and patient assignments ensure time for nurses to chart.

Insufficient staffing levels to provide safe and proper nursing care:

3. That the baseline RN staff complement is increased to provide proper and safe nursing care of patient on Inpatient Surgical Unit, and the Observation Unit where nursing care needs require increased responsive nursing care and in a higher priority of need.

4. Baseline RN staffing must be supported with available RN part time staff to be able to respond to the needs of Inpatient Surgery patient care needs on short notice.

5. Staffing schedule must reflect time build (sic) into the RN baseline schedule to meet the unpredictable nature of surgical patient outcomes both pre-op and post-op.

6. Promote continuity of care, and communication between multidisciplinary care teams and support staff communication by extending the compliment (sic) of the resource/charge nurse in hours from what is currently from 0700 hrs to 1900 hrs to be extended to 2300 hrs during the week days of Mon-Fri and an addition of two RNs on the weekend baseline staff to take the resource/charge nurse responsibilities on Sat-Sun from the hours of 0700-1900 hrs on each end of the unit.

7. That the baseline support staff complements be adjusted. In such a way that they provide timely, appropriate and safe assistance to nursing staff and to other disciplines that work with the patients in the Inpatient Surgical Unit, i.e. physiotherapy.

Effective formal staffing plans should be implemented in all organizations employing nurses.

8. Ensure that relief staff are consistently available to cover unexpected short term vacancies (vacation) and short notice replacements (sick leave, alterations in acuity) by monitoring the proportion of casual staff who are pre-booked in each two week period, and hiring additional staff as per collective agreement.

9. The formal staffing plans should be developed at the organizational and unit levels in consultation with front-line nurses through a process which allows nurses to control their practice as well as influence administrative decisions.

10. Formal staffing plan that is to be developed for the unit should identify expected nurse-patient ratios; skills scopes of practice staffing models; and resources required for quality of care.

11. Formal staffing plan should recognize the complexity involved with the appropriate matching of nurses’ and other care provider’s skills, education and experience with patient’s needs.
Appendix IX

Grand River Hospital Recommendations

1. The Hospital relocate the Observation Unit to ICU as soon as possible.
   - This will eliminate two (2) beds on the Inpatient Surgery Unit and eliminate the need to fill a daily tour with part-time staff.
   - This will result in a consistent 1:5 patient ratio on the entirety of the Unit and provide an extra experienced part-time Nurse to be available for staffing the Unit.

2. The Hospital, via the Inpatient Surgery Unit Council, monitor issues arising from the implementation of the new April 6, 2007 schedule.
   - Again, the Unit staff have indicated that Unit Council is the desired vehicle for issues to be addressed and discussed.
   - The new schedule, arrived at with input of all staff, including ONA, has attempted to address the complaints raised. Follow-up is required to determine the success of these ongoing efforts.

3. The Hospital finalize the implement guidelines for Portering after 1830h and on weekends.
   - As discussed, this will clarify responsibility for patient transfer after 1830h and on weekends. This responsibility falls first on PACU Nurses, then on the Hospital-wide Portering service, and only then to Inpatient Surgery Unit Nurses.
   - This will assist in addressing the ongoing complaints regarding Portering

4. ONA educate its members on proper utilization of Professional Responsibility Workload Report Forms and the need for ongoing discussion of workload issues with Hospital management as an essential component of this process.

5. ONA educate its members on reporting and communicating proper availability for part-time staff.

6. The Hospital complete and implement the proposed staff satisfaction survey for the Inpatient Surgery Unit.
   - This will assist the Hospital in understanding satisfaction issues, including morale issues on the Inpatient Surgery Unit.

7. The Hospital complete its ongoing project in relation to equipment ordering and maintenance in relation to the Inpatient Surgery Unit.
   - This will address the issue raised regarding equipment shortages.

8. The Hospital complete its ongoing project in relation to the Inpatient Surgery Unit supply room.
   - This will assist in the availability of supplies.