Independent Assessment Committee Report

Constituted under Article 8.01 of the Collective Agreement between

Ontario Nurses Association and Church and Finch Street sites of the Emergency Program, Humber River Hospital

and

Ontario Nurses’ Association

March 3rd 2013
Independent Assessment Committee

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March 4th 2013

Dear Mariana and Sarah

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 in the Emergency Program (Church and Finch Street sites), Humber River Hospital.

The Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement (expiry March 2014) between the Humber River Hospital and the Ontario Nurses' Association.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Hospital and the Association and the Registered Nurses of the Emergency Program (Church and Finch Street sites), to prepare and present information and respond to our questions prior to and during the three day hearing.

The attached Report includes a number of unanimously submitted recommendations which we hope will assist all parties to continue to work together, in good faith, to provide optimal care to patients accessing care within the Emergency Program (Church and Finch Street sites).

Respectfully submitted

June Duesbury-Porter RN, MScN, MBA  
Chair, Independent Assessment Committee

Jo-anne Marr RN, MScN, MBA, CHE  
Humber River Hospital Nominee

Cindy Gabrielli, RN (EC) MScN  
Ontario Nurses Association Nominee
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Independent Assessment Committee's report
Church and Finch Street sites of the Emergency Program, Humber River Hospital and Ontario Nurses Association
March 3rd 2013
PART I INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (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** Presents the context of practice relating to the professional workload complaint in the Church and Finch Street sites of the Emergency Program, Humber River Hospital; briefly summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses’ Association ("the Association") and Church (CSS) and Finch Street (FSS) sites of the Emergency Program, Humber River Hospital ("the Hospital") at the Hearing.
- **Part III** Presents the IACs’ discussion, analysis and recommendations.
- **Part IV** Summary and Conclusions.
- **Part V** Contains Appendices referenced in the Report.

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Emergency Program (Church and Finch Street sites) of the Emergency Program, Humber River Hospital. The Association Local 68 outlines in their pre-hearing submission that:

The RNs working the Hospital’s Emergency Departments on both the Church and Finch Street sites began to consistently document their workload and practice concerns in earnest on Professional Responsibility Workload Report forms in 2010. The Hospital and the Association discussed the workload concerns specific to the ED through the Hospital Association Committee (HAC) process since October 2010. The Professional Responsibility Pre—Complaint Letter was forwarded to the Hospital on March 13th 2012. An Association’s Professional Practice Specialist has been involved since March 2012.

Four Sub-HAC meetings have been held since April 2012 in an attempt to address the issues identified by the RNs working within the Church and Finch Street sites of the Hospital’s Emergency Program. Notwithstanding recent statistical improvements in patient flow and patient wait times; serious endemic practice and workload concerns remain unresolved.

Therefore in the Association’s Professional Responsibility Complaint to the IAC Chairperson, in a letter dated September 27th 2012 a request that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent and professional quality patient care in a quality practice setting in accordance with the College of Nurses of Ontario Practice Standards and Guidelines.

1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Central Hospital Agreement between the Ontario Hospital Association/Humber River Regional Hospital (now known as the Humber River Hospital) and the Ontario Nurses Association. Article 8.01 relates to Professional Responsibility and
identifies the process to be followed in the event of a concern regarding the provision of proper patient care.

8.01 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:

(a) i) at the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources

ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.

iii) Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with her or his Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within five (5) calendar days whichever is sooner. Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the ONA/Hospital Professional Responsibility Workload Report Form to the nurse(s) within 5 days of receipt of the form with a copy to the Bargaining Unit President.

When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist her/him at the meeting.

iv) Every effort will be made to resolve workload issues at the unit level. A Union representative shall be involved in any resolution discussions at the unit level. The discussions and actions will be documented.

v) Failing resolution at the unit level, submit the ONA/Hospital Professional Responsibility Workload Report Form to the Hospital-Association Committee within twenty (20) calendar days from the date of the Manager’s response or when she or he ought to have responded under (iii) above. The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the ONA/Hospital Professional Responsibility Workload Report Form. The Committee shall hear and attempt to resolve the issue(s) to the satisfaction of both parties and report the outcome to the nurse(s).

vi) Prior to the issue(s) being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the issue(s) and recommendations to the Chief Nursing Executive:

For professionals regulated by the RHPA, other than nurses, the Union may forward a written report outlining the issue(s) and recommendations to the appropriate senior executive as designated by the Hospital.

vii) Any settlement arrived at under Article 8.01 (a) iii), iv), or v) shall be signed by the parties.

(Article 8.01(a), (viii), (ix) and (x) and 8.01(b) applies to nurses only)
viii) Failing resolution of the issue(s) within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the issue(s) 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.

If one of the parties fails to appoint its nominee within a period of forty-five (45) calendar days of giving notice to proceed to the Independent Assessment Committee, the process will proceed. This will not preclude either party from appointing their nominee prior to the commencement of the Independent Assessment Committee hearing.

ix) The Assessment Committee shall set a date to conduct a hearing into the issue(s) 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 render its decision, in writing, to the parties within forty-five (45) calendar days following completion of its hearing.

x) It is understood and agreed that representatives of the Ontario Nurses’ Association, including the Labour Relations Officer(s), may attend meetings held between the Hospital and the Union under this provision.

xi) Any issue(s) lodged under this provision shall be on the form set out in Appendix 6. Alternately, the local parties may agree to an electronic version of the form and a process for signing.

xii) The Chief Nursing Executive, Bargaining Unit President and the Hospital-Association Committee will jointly review the recommendations of the Independent Assessment Committee and develop an implementation plan for mutually agreed changes. i) The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees.

b) i) The parties agree that should a Chair be required, the Ontario Hospital Association and the Ontario Nurses’ Association will be contacted. They will provide the name of the person to be utilized on the alphabetical listing of Chairs. The name to be provided will be the top name on the list of Chairs who has not been previously assigned.

ii) Should the Chair who is scheduled to serve decline when requested, or it becomes obvious that she or he would not be suitable due to connections with the Hospital or community, the next person on the list will be approached to act as Chair.

iii) Each party will bear the cost of its own nominee and will share equally the fee of the Chair and whatever other expenses are incurred by the Assessment Committee in the performance of its responsibilities as set out herein.

In accordance with Article 8.01 (ix) ‘The Assessment Committee shall render its decision, in writing to the parties within forty-five (45) calendar days following completion of its hearing’.

The IACs’ 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/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for
examinining all factors impacting workload, and for making recommendations to address workload
issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

In the matter of arbitration between Brantford General Hospital and the Ontario Nurses Association
both parties acknowledged that while according to the collective agreement the IAC’s report is not
binding upon the parties, the report carries considerable weight and is accepted by the parties as a
method of obtaining a final dispute resolution in these difficult areas.1

The IACs’ jurisdiction ceases with submission of its written Report. The IACs’ findings and
recommendations are intended to provide an independent external perspective to assist the
Registered Nurses, the Association and the Hospital to achieve mutually satisfactory resolutions. The
IAC is not an adjudicative panel, and its recommendations are not binding. In accordance with
Professional Responsibility Article 8 of the Collective Agreement, the IAC was comprised of three
Registered Nurses. The members were:

For the Association:
Cindy Gabrelli

For the Hospital:
Jo-anne Marr

Chairperson
June Duesbury-Porter

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1 Arbitration Hearing Brantford General Hospital and Ontario Nurses Association, September 8th 1986
1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

The Association in a letter dated September 27th 2012 notified the Hospital that in accordance with Article 8.01 of the Central Hospital Agreement between the parties, ONA was forwarding this Professional Responsibility Complaint to the Independent Assessment Committee (IAC). Within a letter dated Thursday, September 27th 2012 the Association advised the Hospital that the Associations’ nominee to the IAC was Cindy Gabrielli (see Appendix 1).

On Wednesday, October 31st 2012 Mr. Jason Green communicated via the Hospital that the Hospital was unable to accommodate any three (3) consecutive days until the week March 1st - 13th 2013. Since the only three (3) consecutive days put forward was during the annual March Break and no alternatives were suggested the Independent Committee exercised this right to set the date which was the original one proposed. The IAC Chairperson on October 31st 2012 wrote to Jason Green, the Hospital’s legal counsel on Wednesday, October 31st in a letter indicating that the IAC was setting the date of the hearing for Monday, January 15th - Thursday, January 17th 2013 in accordance with Article 8.01.

On Wednesday, November 21st 2011 the Hospital advised the Association that the Hospital’s nominee was Jo-anne Marr.

A teleconference was held on Wednesday November 28th 2012 between the Hospital’s Jo-Anne Marr and the Association’s nominee Cindy Gabrielli. The IAC Nominees discussed potential dates for the Hearing with their respective parties over the following weeks which were also shared with both the Hospital and Association.

The IAC, the Hospital and the Association agreed that the Hearing would be held at the Holiday Inn Yorkdale on January 15th-17th 2013.

The IAC requested the Hospital and the Association to forward the Hearing Submission and associated exhibits to the Chairperson by Monday December 3rd 2012 in order to support the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance. The IAC Chairperson received the Association Submission Briefs and associated exhibits on Monday December 3rd 2012 as requested, and distributed the Briefs and exhibits by courier to all parties on December 4th 2012. The Hospital’s copy was couriered to Catherine Green Manager, Labour Relations in the absence of the contact details of their legal counsel. The IAC Chair only received one copy of the Hospital’s pre-hearing submission and confirmed that the other 3 copies had been forwarded to the Association and both their and the Hospital’s nominees.

The IAC held a teleconference Pre-Hearing Meeting on Thursday January 2nd 2013. The IAC during this meeting:

- Reviewed the anticipated process of the Hearing;
- Discussed the themes arising from the pre-hearing submissions and exhibits provided by both the Hospital and the Association;
- Identified key personnel to interview
- Determined the additional information requirements in selected areas;
- Constructed a draft agenda;
- Identified the key issues for in depth clarification and exploration at the Hearing.

Following this meeting, the IAC Chairperson wrote to the Association and the Hospital for the purpose of:

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Independent Assessment Committee's report
Church and Finch Street sites of the Emergency Program, Humber River Hospital and Ontario Nurses Association
March 3rd 2013
• Confirming the plans and attendees for the Tour of Church and Finch Street sites of the Emergency Program;
• Providing the Hearing Agenda;
• Requesting the Hospital to provide selected additional information by the close of the Hearing (Appendix 2).

The Hospital and Association provided the IAC Chair with their respective lists of tour participants on Thursday January 10\textsuperscript{th} 2013. On the morning of Tuesday January 15\textsuperscript{th} 2013 the IAC were greeted in the lobby by tour representatives from both the Hospital and Association. The IAC was provided a place for their personal effects prior to commencing the tour.

On behalf of the Association on the Church Street site tour was:
• Samuel Aikuluia RN, ER Church Site ONA Unit Rep
• Valerie Wakefield, RN, ER Church Site
• Michael Howell, BUP and LC Local 68
• Mariana Markovic, Professional Practice Specialist, LRO, ONA

On behalf of the Association on the Finch Street site tour was:
• Franca Ruggiero, RN, ER Finch Street site
• Tracey Leathers, RN, ER Street site
• Michael Howell, BUP and LC Local 68
• Mariana Markovic, Professional Practice Specialist, LRO, ONA

On behalf of the Hospital: on the Church Street site tour was:
• Mayda Timberlake, Manager Church Street site
• Barbara Willitts, Director, Acute Medicine, Emergency Services, Geriatrics, Inpatient Rehab, Endoscopy, Family Practice & Neurodiagnostics
• Catherine Green, Manager, Labour Relations
• Sarah Eves, Legal Counsel

On behalf of the Hospital: on both of the Finch sites were:
• Diana Avgeninos, Manager Finch Street site
• Barbara Willitts, Director, Acute Medicine, Emergency Services, Geriatrics, Inpatient Rehab, Endoscopy, Family Practice & Neurodiagnostics
• Catherine Green, Manager, Labour Relations
• Sarah Eves, Legal Counsel

1.4.2 Hearing

The Hearing convened at 1300 hours at the Holiday Inn Yorkdale, Toronto in concordance with the Agenda (Appendix 3), the Hearing was held over three days:

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<th>Day</th>
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<th>Time</th>
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<tbody>
<tr>
<td>Tuesday</td>
<td>January 15\textsuperscript{th} 2013:</td>
<td>0800 — 1700 hours</td>
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<tr>
<td>Wednesday</td>
<td>January 16\textsuperscript{th} 2013:</td>
<td>0800 — 1700 hours</td>
</tr>
<tr>
<td>Thursday</td>
<td>January 17\textsuperscript{th} 2013:</td>
<td>0800 — 1500 hours</td>
</tr>
</tbody>
</table>

Participants and Observers on the respective hearing dates are listed in Appendix 4.
Tuesday January 15th 2013

The IAC arrived at the Church Street site ED at 730 hours and were met by both Hospital and Association tour members prior to proceeding with a tour beginning with Triage and subsequently included the following areas:

- Offload
- Ozone
- Clinical Decision Unit
- Minor Treatment
- Location of Resuscitation/Acute area
- Mental Health Crisis Team at Church after medical clearance

The tour facilitated a greater understanding of the patient flow in relation to the unit floor plans provided by the Hospital in their pre-hearing submission.

The IAC also had the opportunity to meet with Caroline Mellor, Commander Dedicated Offload Delay Nurse Program, Toronto, Emergency Medical Services from 1030-1130. Although the Hospital and Association had representatives present, the IAC requested that they refrain from taking notes. The conversation with Caroline Mellor provided the IAC with additional insight into the offload issues experienced by EMS at both the Church and Finch Street site. During the meeting, it was confirmed that the EMS funding provided was indeed for a Registered Nurse as opposed to either a RN or RPN. It was also confirmed that EMS only provides funding to the Hospital when an Offload Nurse is in place.

The IAC Chairperson opened the Hearing shortly after 1300. Following introduction of the IAC Committee members and round-table introductions of the Association and Hospital participants, the IAC Chairperson reviewed:

- The jurisdictional scope of the IAC, including the purpose of the IAC;
- The scope of its recommendations, and the processes agreed to by the Hospital and the Association as outlined in Section 8.01 of the Collective Agreement.
- The ‘ground rules’ for the Hearing procedure including confirmation that all participants understood and agreed.

Mariana Markovic, Professional Practice Specialist presented on behalf of the Association. The content of the Association’s presentation was based on their written Pre-hearing submission and exhibits of supporting / explanatory information, as well as a summary of the PRWRFs submitted by the Registered Nurses within the Church and Finch Street sites of the Emergency Program between date2010 until present and date. During the presentation the Association reaffirmed their position that the introduction of the new model of care and Ozone had negatively impacted the workload of the Registered Nurses at both the Church and Finch Street sites of the Hospitals’ Emergency Program. During and following the presentation, the Association responded to clarification questions posed by both the Hospital and IAC.

Sarah Eves, Legal Counsel for the Hospital presented the submission on behalf of the Hospital. The content of the Hospital’s presentation was based on their written pre-hearing submission and position that the new model of care etc. had not impacted the workload of the Registered Nurses working within the Church and Finch Street sites of the Hospital’s Emergency Program.

During and following the presentation, the Hospital responded to clarification questions posed by the Association and IAC.

The IAC would like to draw attention to the fact that the Hospital made reference to grievances copies of which were contained in their written pre-hearing submission and during their hearing presentation.
In response to this the IAC made it categorically clear that labour relation issues, grievances, arbitration etc. are beyond the scope of Article 8.01 and were neither interested in perusing this train of thought nor would the IAC factor information of this nature into their report and the recommendations contained within.

The IAC Chairperson adjourned the Hearing at 1700 hours. The IAC then proceeded to make their way to the Finch Street site to both meet with the Hospital’s Chief of Emergency, Dr. Nalin Ahluwalia and tour the emergency department.

Similar to the meeting with EMS earlier in the day, the IAC requested that the Hospital and Association, although present, refrain from taking notes. The IAC gained considerable insight in the operations of the Emergency Program from the Chief's perspective including the relationship between the ED physicians/RNs and code bed designation. While it is early days given Dr. Ahluwalia has only been in post for six months, he did outline that he had already made changes to the ED physicians’ schedule to more appropriately match their coverage to patterns of ED visits.

The IAC following the meeting with Dr. Ahluwalia toured the Finch Street site, beginning with Triage and subsequently included the following areas:

- Offload
- Ozone
- Clinical Decision Unit
- Minor Treatment
- Location of Resuscitation/Acute area

Following adjournment of the tour the IAC met over dinner to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion on the second day of the hearing.

**Wednesday January 16th 2013**

**Finch Street Site Tour:**

The IAC arrived at the Finch Street site to tour the Emergency Department at the beginning of the morning shift. During the tour the IAC had an opportunity to observe one of the Huddles which are led by the Manager and serve to share key information, performance, for staff to communicate some of their issues, as well as a timely way to recognize staff and others for the great work that they have done.

Following the huddle and breaking from the predetermined tour agenda the IAC requested a meeting with the RNs who were part of the tour as well as any others who would be available to attend. In conversation the IAC explained that they felt there was further insight to the day to day operation of the ED to be gained from the RN perspective. The IAC Chair, in further conversation with Association and Hospital representatives; received agreement that they were in support of this and would also have representatives present, although to ensure that RNs participating would feel comfortable they would refrain from taking notes. The Hospital and Association’s representatives were:

- Samantha Crumb, Legal Counsel, Hospital
- Sheri Street, Labour Relations Officer, for the Association

The IAC Chairperson opened the Hearing at approximately 1300 hours. Members in attendance introduced themselves. The ground rules for the Hearing were reviewed and new participants at the Hearing were introduced.
Sarah Eves, Legal Counsel for the Hospital provided the Hospital’s response to the Association’s submission and reaffirmed the Hospital’s position. Members of the Hospital team participated in the discussion following as appropriate.

Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, with the Association, provided the Association’s response to the Hospital’s submission. Other members of the Association team participated in the discussion following as appropriate.

Prior to the end of the hearing, the IAC requested the opportunity to meet with the Hospital’s management to compliment their meeting with the Finch Street site staff earlier in the day. In accordance with the staff meeting representatives from both the Hospital and Association would be present, and as before would refrain from taking notes. It was agreed that the IAC meeting with the Hospital’s management would begin at 0800 and conclude prior to the beginning of the last day of the hearing.

The IAC Chairperson adjourned the Hearing at approximately 1600 hours.

Following adjournment of the Hearing, the IAC had a working dinner on the evening of January 16th 2013 to again review and synthesize the information provided, and to identify key issues requiring additional clarification and their respective questions for the final day of the hearing.

Thursday January 17th 2013

Pre-hearing

- Prior to the commencement of the third day of the hearing the IAC has a specially convened meeting with the management of the Hospital. There was also Sheri Street, Labour Relations Officer, from the Association representative and Samantha Crumb, Legal Counsel for the Hospital present, however, at the request of the IAC were not to take notes. The purpose of the meeting was to compliment the one the IAC had had the preceding day with the RN staff on the Finch Street site.

Hearing

The IAC Chairperson opened the Hearing at 0915 hours, reviewed the ground rules and asked the Hospital and Association to introduce any new participants.

The IAC Chair took the opportunity to acknowledge to both the Hospital and the Association stating that the IAC has heard their positions and therefore there was no need for them to recap. The Chair further added that it was therefore the intent of the IAC to focus on the respective questions they had and also ensure that the staff had an opportunity to speak.

Members of the IAC posed a range of questions to review issues in more detail and requiring further clarification arising from both parties’ presentations and ensuing discussion with both the Hospital and the Association in an open Question and Answer session. All hearing participants actively participated.

The IAC Chairperson thanked the participants for their commitment to the Hearing process and for their active and open discussion during the Hearing. The Chair noted the IACs’ recognition of the challenges, for both parties, associated with open and honest dialogue, and reiterated the IACs’ hope that the opportunity for discussion during the Hearing would enable both parties to move forward. She reaffirmed that the IACs’ Report and associated recommendations are intended to provide all concerned (Registered Nurses, the Association and the Hospital) with an independent external perspective to aid in the resolution of outstanding issues, and are not binding. She confirmed that the IACs’ Report would be distributed by courier within the required 45 days.
The IAC Chair closed with sharing the following consensus recommendations which would be in the report, but was not an all inclusive list of recommendations that would be contained in their report:

1. To improve the interprofessional team inclusive of clarification of roles and responsibilities;
2. Build on the EDPIP work undertaken to date;
3. There are benefits to be realized from ceasing the practice of caring for an inpatient post coded in the ED;
4. Given funding for the Off Load is for RN it should be staffed as such;
5. More work needs to be undertaken to provide for a work environment where stakeholders feel safe and secure; and
6. The above is not an all inclusive list of potential.

The IAC Chairperson closed the Hearing at 1245 hours.

Post Closure of Hearing

The IAC met briefly immediately following the hearing on Thursday January 17th 2013 over a working lunch to reflect on the issues identified, confirm themes and outline how the construction of the recommendations would unfold. The IAC also confirmed the date of their next meeting which was to be Tuesday February 12th 2013 to review and refine the recommendations.

Between the close of the Hearing on and submission of the electronic PDF Report on March 4th by e-mail, followed by a hard copy being couriered to both the Hospital and Association the IAC undertook the following in the development of this report:

- All three members of the IAC drafted specific recommendations in addition to putting forth their respective ideas for recommendations where there were not assigned the initial drafting of specific ones
- A full-day meeting on February 12th 2013 to draft the outline of the Report and to discuss the findings and proposed recommendations in depth;
- From February 13th through 19th the recommendations underwent further revisions by all three members;
- Independent review of the first draft;
- A teleconference on insert Wednesday February 20th 2013 to further discuss the findings and proposed recommendations in depth for the purpose of refining the report further;
- Final agreement of the IAC who agreed that there would be consensus on Recommendation and of the IAC report was on February 22nd 2013;
- The Final Report was submitted to the Association and the Hospital by courier on March 3rd 2013.
PART II PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Context of Practice

As stated in the Hospital’s pre-hearing submission:

On July 14th 2009 the Hospital CEO Dr. Rueben Devlin, wrote to all Hospital staff and physicians outlining plans to specifically:

- Implement a new model of nursing care, one that will enhance our hospital’s ability to deliver high quality patient care as efficiently and effectively as possible
- Hire approximately 80 diploma prepared Registered Practical Nurses (RPNs)
- No layoffs
- Reduce current workload, address the accountability and continuity of care issues that arise from using agency staff, reduce agency premium and overtime costs

The Hospital indicated that all RPNs work to the full scope to their practice as defined by the College of Nurses of Ontario and feel that the Association has not demonstrated that their concerns have negatively impacted patient care. The Hospital further asserted in their pre-hearing submission and during the hearing that from their perspective RPNs have not had a negative impact on patient care in emergency.

As stated in the Association’s pre-hearing submission:

Beginning in October 2010 the Association cited concerns with fluctuating staffing and workload, patient acuity and professional responsibility for RNs working at the Church and Finch Street sites citing common concerns which included:

- Understaffing, overtime, no sick call replacement
- High number of junior staff (up to five (5)/shift)
- One-three (1-3) senior RNs per shift, one of which assuming the Charge Role
- Two-five (2-5) agency RNs at a time (no computer training) on a shift
- RNs working overtime
- High volume of:
  - Patients within the ED
  - No bed admits (15-20), including those in hallway
  - Increased volume of CTAS 2 patients
  - Patients in the ED
- Minimal support staff i.e. unit clear and aides
- Shortage of equipment such as IV pumps and poles, monitors, wheel chairs and stretchers

2.1.1 Structure of Church and Finch Street sites of the Emergency Program

The Hospital’s Emergency Program is located on two distinct sites: Church and Finch Street. The Hospital’s organizational statistics report:

- Church Street site having 55,850 ED visits
- Finch Street site having 52,157 ED visits

The layouts of the respective sites reflect both the age of the building as well as numerous improvements which have been made over the subsequent years. Both sites have the following patient care areas which are common to emergency departments:
- Triage
- Offload
- Minor Treatment
- Ozone (rapid assessment)
- Resuscitation and acute care

The Church Street site also benefits from having a Mental Health Crisis Team which is available after medical clearance.

2.1.2 Patient Population

The Hospital is considered by the MOHLTC a high volume community hospital and are incrementally increasing year on year and is illustrated in Tables 1, 2 and 3. The patient population served by the Hospital's emergency departments includes;

- Culturally diverse population
- Adult, pediatric, and elderly:
  - Regional pediatrics at Finch;
  - Increased mental health and elderly at Church; in keeping with their inpatient facilities

Table 1: Hospital Emergency Program's Total ED Visits by CTAS

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<tr>
<th>Year</th>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>2009/10</td>
<td>722</td>
<td>22,430</td>
<td>54,181</td>
<td>22,038</td>
<td>535</td>
<td>99,906</td>
</tr>
<tr>
<td>2010/11</td>
<td>695</td>
<td>22,193</td>
<td>57,322</td>
<td>21,072</td>
<td>570</td>
<td>101,852</td>
</tr>
<tr>
<td>2011/12</td>
<td>759</td>
<td>24,602</td>
<td>61,080</td>
<td>19,543</td>
<td>610</td>
<td>106,594</td>
</tr>
<tr>
<td>YTD Sept</td>
<td>321</td>
<td>12,337</td>
<td>29,232</td>
<td>10,361</td>
<td>236</td>
<td>52,487</td>
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Table 2: Church Street site Total ED Visits by CTAS

<table>
<thead>
<tr>
<th>Year</th>
<th>CTAS</th>
<th></th>
<th></th>
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<th>Total</th>
</tr>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2009/10</td>
<td>323</td>
<td>8,897</td>
<td>31,506</td>
<td>10,102</td>
<td>321</td>
<td>51,149</td>
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<tr>
<td>2010/11</td>
<td>331</td>
<td>9,544</td>
<td>33,210</td>
<td>9,786</td>
<td>349</td>
<td>53,220</td>
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<td>2011/12</td>
<td>360</td>
<td>11,581</td>
<td>33,856</td>
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<td>YTD Sept</td>
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<td>15,781</td>
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Table 3: Finch Street site Total ED Visits by CTAS

<table>
<thead>
<tr>
<th>Year</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2009/10</td>
<td>399</td>
</tr>
<tr>
<td>2010/11</td>
<td>364</td>
</tr>
<tr>
<td>2011/12</td>
<td>399</td>
</tr>
<tr>
<td>YTD Sept 9/12</td>
<td>179</td>
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</table>

2.1.3 Church and Finch Street Sites Staffing

The respective sites are currently staff with Physicians, RN, RPNs and Support Staff. The following Tables outline the baseline and assignments for both Church and Finch Street sites.

Staffing Data

Church and Finch Street sites of the Emergency Program are staffed with Physicians, RNs, RPNs and Support Staff as per the Hospital’s pre-hearing submission and is illustrated in Tables 4, 5, 6 and 7. The pre-hearing submissions and tour reflected the presence of a physician assistant, however, their hours of work in the format below was not provided to the IAC and are therefore not included in the following Tables in this section.

Table 4: Church Street Site Baseline Staffing

<table>
<thead>
<tr>
<th>Shift</th>
<th>Hours</th>
<th>RNs</th>
<th>RPNs</th>
<th>Physicians</th>
<th>Support Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>0700-1400</td>
<td></td>
<td></td>
<td>1</td>
<td>1 Clerical</td>
</tr>
<tr>
<td></td>
<td>0730-1930</td>
<td>10 + 1 Charge Nurse</td>
<td>1</td>
<td>2 Registration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0730-1500</td>
<td></td>
<td></td>
<td></td>
<td>1 Unit Aide</td>
</tr>
<tr>
<td></td>
<td>1000-1700</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1000-2200</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1130-2330</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1200-2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1400-2200</td>
<td></td>
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<td>1</td>
<td>2 Clerical</td>
</tr>
<tr>
<td></td>
<td>1530-2330</td>
<td></td>
<td></td>
<td></td>
<td>1 Registration/Bed Allocation</td>
</tr>
<tr>
<td></td>
<td>1530-2400</td>
<td></td>
<td></td>
<td>1</td>
<td>1 Registration</td>
</tr>
<tr>
<td></td>
<td>1600-2400</td>
<td></td>
<td></td>
<td></td>
<td>1 Unit Aide</td>
</tr>
<tr>
<td>Nights</td>
<td>1900-0230</td>
<td>10 + 1 Charge Nurse</td>
<td>1</td>
<td>1 Clerical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1930-0730</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1 Registration/Bed Allocation</td>
</tr>
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<td></td>
<td>2330-0730</td>
<td>1</td>
<td></td>
<td></td>
<td>1 Registration</td>
</tr>
<tr>
<td></td>
<td>2330-0930</td>
<td></td>
<td></td>
<td></td>
<td>1 Unit Aide</td>
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</table>
# Table 5: Church Street Site Staffing and Assignments

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Day-Shift 0730-1930</th>
<th>Evening Shift 1130-2330</th>
<th>Night Shift 1930-0730</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Charge Nurse</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Triage</td>
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<td>3</td>
</tr>
<tr>
<td>Center (4 beds)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Acute (1-5)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Sub-Acute (9-14)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Ozone</td>
<td>2</td>
<td>1 RPN</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Decision Unit</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Minor Treatment</td>
<td>1 RPN</td>
<td></td>
<td>1 RPN</td>
<td></td>
</tr>
<tr>
<td>EMS Offload</td>
<td></td>
<td>*RPN</td>
<td>1 RPN</td>
<td>2.75</td>
</tr>
<tr>
<td>Total RN</td>
<td>11</td>
<td>13</td>
<td>11</td>
<td>23</td>
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<tr>
<td>Total RPN</td>
<td>1</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>14</td>
<td>13</td>
<td>39</td>
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</table>

# Table 6: Finch Street Site Baseline Staffing

<table>
<thead>
<tr>
<th>Shift</th>
<th>Hours</th>
<th>RNs</th>
<th>RPNs</th>
<th>Physicians</th>
<th>Support Staff</th>
</tr>
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<tbody>
<tr>
<td>Days</td>
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<td></td>
<td>1</td>
<td>1 Clerical</td>
</tr>
<tr>
<td></td>
<td>0730-1530</td>
<td></td>
<td></td>
<td></td>
<td>2 Registration</td>
</tr>
<tr>
<td></td>
<td>0730-1930</td>
<td>9 + 1 Charge Nurse</td>
<td>1</td>
<td>1</td>
<td>1 Unit Aide</td>
</tr>
<tr>
<td></td>
<td>1000-2000</td>
<td></td>
<td></td>
<td>1</td>
<td>2 Clerical</td>
</tr>
<tr>
<td></td>
<td>1000-2200</td>
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<td></td>
<td>1</td>
<td>1 Registration/Bed Allocation</td>
</tr>
<tr>
<td></td>
<td>1130-2330</td>
<td></td>
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<td></td>
<td>1 Registration</td>
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<tr>
<td></td>
<td>1300-2200</td>
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<td>1 Unit Aide</td>
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<td></td>
<td></td>
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<td>1 Registration/Bed Allocation</td>
</tr>
<tr>
<td>Nights</td>
<td>1800-0300</td>
<td></td>
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<td>1</td>
<td>1 Clerical</td>
</tr>
<tr>
<td></td>
<td>1930-0730</td>
<td>9 + 1 Charge Nurse</td>
<td>1</td>
<td>1</td>
<td>1 Registration</td>
</tr>
<tr>
<td></td>
<td>2330-0730</td>
<td></td>
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<td>1 Registration/Bed Allocation</td>
</tr>
<tr>
<td></td>
<td>2330-0930</td>
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<td>1</td>
<td>1 Unit Aide</td>
</tr>
<tr>
<td>Assignment</td>
<td>Day-Shirt 0730-1930</td>
<td>Evening Shift *1000-220 1130-2330</td>
<td>Night Shift 1930-0730 *2330-0730</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Charge Nurse</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Triage</td>
<td>1</td>
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<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>Acute 1</td>
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<td>2</td>
<td>2</td>
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<tr>
<td>Acute 2-4</td>
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<td>2</td>
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<tr>
<td>B 25-27/Hall</td>
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<td>1</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Ozone</td>
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</tr>
<tr>
<td>Minor Treatment</td>
<td>1 RPN</td>
<td>1 RPN</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>EMS Offload</td>
<td>1</td>
<td>*RPN</td>
<td>2.5</td>
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<td></td>
</tr>
<tr>
<td>Total RN</td>
<td>10</td>
<td>12</td>
<td>10</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Total RPN</td>
<td>1</td>
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<td>1.5</td>
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<tr>
<td>Total</td>
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<td>11.5</td>
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PART III  DISCUSSION, ANALYSIS AND RECOMMENDATIONS

Introduction

The IAC believes that it has obtained a comprehensive understanding of the professional responsibility concerns relating to the Church and Finch Street sites of the Emergency Program of the Hospital. This was achieved through review and analysis of the written submissions and exhibits, the oral presentations and discussion, and the thoughtful comments made by the Hearing participants in response to questions posed by the IAC.

The IAC has based its comments and advice on the perspective that 'nursing workload' has been 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 (inclusive of agency and overtime), and indirect factors, such as leadership, communication, opportunities for development, staff mix and processes and systems of care. A practice environment that supports and respects the professional practice of nurses will result in the provision of safe and efficient care of patients and retention of health care staff.

The Hospital unfortunately provided very little of the requested additional material in support of their pre-hearing submission during the hearing from January 15th-17th. The Hospital repeatedly cited the installation of Medites version 6 earlier in the 2012/13 budget year and subsequent writing of the necessary reports has not been undertaken to provide what the IAC perceive as routine operational data. The IAC remained very disappointed with the limited amount of additional information requested being provided.

BACKGROUND

IMPLEMENTATION OF NEW MODEL OF CARE

Throughout the pre-hearing submission and hearing presentation, Humber River Hospital (HRH) and hereafter referred to as the 'Hospital' reinforced the fact that the change in skill mix was a result of an obligation to submit a balanced budget. HRH was advised by the Central Local Health Integration Network (C-LHIN) to work with the Hay Group consulting firm who would lead a benchmarking exercise with the Hospital leadership team to examine its administrative and operational structure and make recommendations to improve its operating position and to develop strategies to deal with an expected funding shortfall and related budget issues. The Hay Group presented the final results of the review process to the Hospital's senior team in August 2009. Members of Hospital management met with union representatives, including ONA representatives in January/February 2009 to review the Hay Group’s recommendations and results. Union representatives on the Hospital Fiscal Advisory Committee (FAC), including ONA representatives, were regularly informed of the progress of the work undertaken by the Hay Group.

The Hay Group also noted the costs incurred by the Hospital due to Registered Nurse (RN) agency utilization. The agency use resulted from regular agency staffing to backfill RN vacancies as well as overtime hours. They recommended an evaluation of the 'staff mix', among other things as a strategy to reduce costs incurred as a result of longstanding shortage of RNs.

The Hospital accepted the Hay Group's recommendation to implement a new model of nursing care. As part of this new model, the Hospital would need to eliminate a number of 'vacant and historically unfilled RN positions' and increase its recruitment of Registered Practical Nurses (RPNs). It was expected that with these changes, the Hospital would be able to reduce the RN agency and overtime costs and provide consistent staffing to enhance both quality and continuity of care for patients.

On July 14th 2009, the Hospital CEO Dr. Rueben Devlin, wrote to all Hospital staff and physicians outlining plans to implement a new model of nursing care including its underlying rationale.
CURRENT STATE

While the intent of the new model introduced in 2009 within the Emergency Department was to reduce costs associated with both agency and overtime, the chart below illustrates that this has not yet been realized. For the purpose of table 8 below the Agency and Overtime has been extrapolated for the 2012/13 budget year based on usage up to November 2012 as provided by the Hospital.

Table 8:

![Chart showing Agency Nurse Utilization, Overtime, and Sick Time for 2009/10 to 2012/13]

Independent Assessment Committee Recommendations

The IAC believes that the key issues impacting the professional practice environment in the Emergency Departments at both Church and Finch Street sites relate to Communication, Staffing, Change Management, Processes, Safety and Security and the Physical Environment.

COMMUNICATION

Communication is an integral part of a healthy and safe work environment and is inclusive of all interactions among providers as well as the management team. Effective communication is essential to support the interdisciplinary team in providing quality patient care.

Recommendation 1: The Hospital must improve communications among key stakeholders

The Independent Assessment Committee (IAC) identified the need for improved communication as a recurrent theme throughout the hearing. During the hearing the IAC was made aware that there have been opportunities for staff to provide input regarding departmental changes. This included but was not limited to changes such as those made in the Ozone. The IAC also heard that there were regular staff meetings with pre-circulated agendas for staff, and observed team huddles. These huddles are considered a best practice and are a great way to share key information, performance, for staff to
communicate some of their issues, as well as a timely way to recognize staff and others for the great work that they have done. The IAC recognizes that the Hospital has a foundation on which to build and create broader and more frequent, lines of communication.

Recommendation 2: The Hospital should respond to substantive concerns raised by nurses within 14 calendar days

During the hearing the IAC heard the nurses express concerns regarding the absence of feedback as well as the prolonged time that it took for issues to be brought forward, resolved and for the feedback loop to be closed. The IAC appreciates that it does take time for the manager to investigate issues appropriately however, the IAC considers it reasonable that the nurse or nurses would receive a response within 14 calendar days. If the issue resolution is complicated, an extension period is reasonable and could be mutually discussed. If a longer investigation is warranted, an update must be brought to the nurse or nurses involved at frequent intervals. In the absence of information, frustration and cynicism fills the void.

Timely resolution and closure of issues provides nurses with the reassurance that their issues are taken seriously. Any critical incident, i.e. any sudden unexpected event that has emotional impact that can overwhelm the usually effective coping skills of an individual or a group ² should include a debriefing during which the nurses are allowed time to reflect. This will also foster an environment where nurses are allowed time to extract learnings and develop future strategies to prevent similar incidents. If a debriefing is unable to be accommodated within a reasonable period of time, this should be communicated to key stakeholders and provisions made to secure an appropriate date. The Hospital should utilize their Employee Assistance Program (EAP) or an internal resource with similar skills to support the staff/team.

Recommendation 3: Utilize methods of communication that match the intended or required outcome.

From the Hospital’s pre-hearing submission and discussion during the hearing the IAC learned that the respective Managers of both Church and Finch Street sites held regular staff meetings with opportunities provided in advance for staff to provide input. Additionally, there are regular weekly team ‘huddles’. In addition to these effective face to face opportunities, the IAC believes that there are opportunities to expand the range of avenues of communication in order to optimize reach. The IAC also heard references to information being communicated by e-mail. While e-mail can be effective in sharing information, it is not always the preferred method for communicating changes in practice and or process. The IAC recommends that the Hospital use the suggestions illustrated in Figure 3 to match communication to the desired or intended outcome.

² CON, 2009

Independent Assessment Committee’s report
Church and Finch Street sites of the Emergency Program, Humber River Hospital and Ontario Nurses Association
March 3rd 2013
COLLABORATION AMONG INTERPROFESSIONAL TEAM MEMBERS

Interprofessional collaboration arises from the development and maintenance of effective interprofessional working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships.

Recommendation 4: The IAC recommends formal structures and processes for improving interdisciplinary team communications

   a. Establish an Interprofessional Unit Council to engage staff by September 2013.
   b. Begin planning with staff immediately.
   c. Develop a robust plan inclusive of the following to facilitate communication:
      - Charter (terms of reference including ground rules)
      - Agenda (pre-circulated for items)
      - Minutes
      - Processes for effective dissemination of information

The IAC recommends the implementation of an interprofessional council in which frontline staff can discuss issues and bring solutions forward that can improve patient care operations and quality within the emergency departments. The IAC suggests that this structure will serve to support recommendations related to communication, physician relationships and conflict resolution.

The IAC heard during the hearing, a recurring theme of behavior that was not reflective of staffing working within a supportive interprofessional collaborative team; i.e. RNs feeling intimidated by emergency physicians, specifically the novice nurses. With the new Chief of Emergency in place, and with movement to the new hospital site looming in the fall of 2015, the IAC believes that the timing is critical to better establish a climate characterized by strong interprofessional collaboration.
For interprofessional teams of learners and practitioners to work collaboratively, the integration of role clarification, team functioning, collaborative leadership, and a patient/family/community-centered focus to care/services is supported through interprofessional communication. Effective interprofessional communication is dependent on the ability of teams to deal with conflicting viewpoints and reach reasonable and mutually satisfactory solutions.

Clarification of roles (Recommendation x) will also support the emergency department staff to improve team function. Role clarity can be supported by:

- Self-description of roles and those of others; and
- Effectively accessing others’ skills and knowledge appropriately through consultation.

Another important aspect of interprofessional team functioning is being able to participate fully and to be respectful of all members’ participation in collaborative decision-making.

Recommendation 5: The physician nurse relationship must reflect trust and professionalism. If this is not achieved within the next 8 months, mediation should be completed within the subsequent 3 months.

During the hearing and meeting with staff, relationship concerns between nurses and some emergency physicians were raised. Some staff described extreme emotions related to the impact of what they described as unsupportive and disrespectful behaviours. Such interactions have been shown to negatively impact patient care. The IAC does recognize that not all relationships are characterized as negative however, all conflicts need to be resolved in order to support an optimal team environment to support high quality patient care.

The ED is both chaotic and stressful. The Hospital’s diverse culture of staff and physicians provide care for an equally diverse population with a wide variety of health issues. This environment requires cultural sensitivity, in which interprofessional communication takes on a heightened importance in achieving optimal patient care.

Recommendation 6: Implement a conflict resolution framework within six (6) months.

The IAC accepts that conflict exists in all work environments however, this must be minimized wherever possible. Conflict can occur between staff, managers, physicians and patients. It is the way in which conflict is constructed and addressed where the IAC feels there is opportunity. If conflicts are not addressed in an appropriate and timely manner it will have a deleterious impact on the quality of patient care.

In reviewing the staff survey provided in the submission material, the IAC noted concerns surrounding conflict, including physicians. Satisfactory RN-physician relations are crucial for good patient care. If nurses feel inadequate and powerless they may then act out their frustrations on each other. The IAC also reviewed references on professional responsibility workload forms that cited conflict (verbal abuse) from both patients and their families. Workplace conflicts must be managed to ensure that there is no impact to patient care; this is a shared responsibility among the employer, nurses and physicians who share the responsibility equally. Several factors that contribute to conflict within the

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3 Canadian Health Collaborative, 2010

4 Battholomew, 2006

5 CON, Practice Standard, Conflict Prevention and Management, 2009

Independent Assessment Committee’s report
Church and Finch Street sites of the Emergency Program, Humber River Hospital and Ontario Nurses Association
March 3rd 2013
emergency departments include poor working relationships, perceptions of not being heard or listened to, and increased workload within an already fast-paced environment.

The Hospital has a conflict resolution guideline and a 'no-bullying/abuse' policy in place which the IAC encourages. Both these guidelines and policies need to be actively supported by management, staff and physicians as there is more work to be done to resolve the issues at hand. The Hospital must encourage open communication by staff in which there is no fear of reprisal. Managers must deal with any concerns reported immediately and ensure that confidentiality is maintained. There should be staff education related to conflict resolution. The conflict resolution coaches as per the guidelines, would facilitate a culture of engagement and collaborative problem-solving.

STAFFING

APPROPRIATE AND EFFICIENT STAFFING PLANS

There exists a need to implement staffing plans that utilize the skills and expertise of health care providers. A key piece of this activity involves identification of the appropriate skill level and staffing mix. While it is recognized that there are differences among institutions with respect to patient mix that better support the use of certain providers, some common issues exist. For example many organizations grapple with the challenge of the appropriate level and mix of RN, RPN and Patient Care Assistant (PCA) or Personal Support Worker (PSW) and other unregulated care providers (UCPs) as part of their staffing complements. For the purpose of this exercise we focus on the RN/RPN issue and the use of the most commonly used UCPs in the context of the emergency department experience. Common questions include: What is the appropriate mix of RN and RPN? Is there a role for UCPs such as service associates, PSWs or PCs and Physician Assistants (PAs)? and Is there a role for Nurse Practitioners (NPs)?

Physician assistants (PAs) are understood to be useful as physician extenders to increase physician hours of coverage. As well, the Ministry of Health and Long Term Care (MOHLTC) has supported PA roles most recently. Generally, there is acceptance of the value-add for unregulated roles that support nursing care. The main question relates to whether or not and the extent to which these include patient care functions (e.g. emergency assistants that may perform functions such as casting, catheter insertion and other functions). In departments where the RPN role exists, the query is always whether or not it makes more sense to up-skill the RPN to perform these functions or to assign these functions to a UCP role. The IAC recommends that the Hospital consider the value add of UCP roles in alignment with organizational priorities and the practice model as part of a comprehensive review of staffing levels and mix. For example, if the Hospital determines that it is in the best interest of the department and the organization to support the role of the RPN then the IAC strongly recommends that the RPN role be reviewed for opportunity to expand their scope of functions to ensure that the perceived value add is experienced by the interdisciplinary team and is without increased risk.

The staffing plan should include a review of the patient-specific needs, specific staffing factors and other environmental issues. Patient needs should include activity levels and complexity as well as predictability of outcomes. Staffing factors include competencies and educational preparation (e.g. RPN preparation), experience levels and age of staff and other factors. Environmental issues include practice supports and infrastructure available (e.g. information technology, advanced practice roles etc), stability of the area and geographical layout. It is recommended that the employer engage in a comprehensive review process. A number of tools exist that assist employers to evaluate patient assignment complexity. The IAC recommends that the employer reviews and utilizes tools appropriate to support and validate their decision-making. Some of these tools can be accessed on the College of Nurses of Ontario website.

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Recommendation 7: **Review the staffing complements at both sites and benchmark against peer comparators**

The IAC recommends that the Hospital review the staffing complements at both sites and benchmark against peer comparators. This would include but not be limited to hours of coverage for: RNs; RPNs; unit clerical assistants; PAs and other supporting personnel. The employer may wish to consider up-skilling of the RPNs to perform other skills including casting and other skills within their scopes of practice. Some organizations utilize emergency attendants or other multi-skilled personnel to reduce the workload for the nursing staff. This would include utilizing health care aides to ensure all stocking is complete. This activity could be the focus of a lean initiative.

Recommendation 8: **Review and match patient volume and acuity information by time of day with skill mix**

The literature supports that the presentation rate and the census of an emergency department follow a very predictable pattern and therefore busy times of day are reasonably predictable. It was unfortunate that the Hospital was unable to share with the IAC the CTAS presentation by time of day given the installation of Meditec version 6 earlier in the 2012/13 budget year. That aside, the IAC strongly recommends the use of data regarding patient volume and acuity level to predict and match staffing mix accordingly. This would include but not be limited to patient volume data by CTAS level and time of day to better predict capacity requirements and staffing patterns in various zones of the department. Information of this nature also has the potential to assist in workload leveling and staffing assignments between zones which would go some way to alleviate the staffs’ concerns and that the Ozone area would be less likely to receive patient transfers who were not discharged from Minor Treatment prior to their scheduled close.

Recommendation 9: **Continue with exit interviews and addressing the themes that emerge**

The Hospital stated during the hearing that they undertake exit interviews. The IAC strongly recommends that the Human Resource department of the Hospital continue to consistently undertake exit interviews within the emergency department, that trends be identified and opportunities for improvement be implemented. With solid information, there is an opportunity to incorporate positive change within the workplace and hopefully, reduce the need for exit interviews.

Recommendation 10: **Up-staffing to cover known or planned annual vacancies (e.g. maternity leaves)**

The IAC heard during the hearing that to better serve the emergency departments, RN positions are posted as a program position as opposed to being site specific. The IAC believes that this approach is positive, especially given the move to the new consolidated Greenfield site in 2015.

During the hearing the IAC also heard from the Hospital that there are on average, two to three (2-3) full time maternity leaves per annum that require backfilling on a temporary basis. Given that temporary assignments are less desirable then full time positions, there is an opportunity for the Association and the Hospital to work together to create full time positions for the purpose of backfilling ongoing maternity leaves or other planned absences. The IAC sees that this could benefit the emergency departments in the following ways:

- Decrease and or eliminate the time between commencement of maternity leaves and the start of the backfill;
- Increase retention and therefore experienced RNs within the Emergency Program;
- Decreased need for overtime and Agency Nurse utilization to backfill.

6 http://www.imas.nhs.uk 2010

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Clarifying Roles and Responsibilities

The IAC recommends that this is an opportune time to evaluate and clarify various roles and functions within the team. Completion of this exercise in a collaborative manner and documentation in a matrix format would serve to engage clinicians in the process and simultaneously generate the purposeful dialogue necessary to resolve outstanding concerns about 'who does what' within the team.

Closely related to lean, the creation of standard work is a critical component of improvement. Standard work sets a standard for everyone to follow; it establishes criteria to hold people accountable and defines a baseline to measure against future success and failures. Unless standard work has been created and sustained it is difficult to improve the process. This is particularly important in each of the distinct zones of the department to mitigate the impact of variability of worker productivity and individual work style preferences and the legacy impact of individual processes for individual clinicians.

**Recommendation 11:** Immediately commence the clarification of the role of the RN and RPN. Immediately develop and agree on a set of criteria to support the assignment of patients ‘appropriate’ for RPNs.

It is well documented in the literature that nurse staffing is critical to patient safety, health and well-being. Appropriate staffing in any unit is dependent on having nurses with the right skill, experience and education. Staffing and skill mix involves several factors:

1. Patient and family needs
2. Complexity of environment
3. Nursing complement present and predicted;
   i. Years of experience
   ii. Knowledge and expertise
   iii. Ratio of novice to experienced staff

RPN’s have been employed in the Hospitals’ Church and Finch Street sites since 2009 and work in the following areas:

- Minor Treatment (fast track);
- Ozone area
- Offload and
- In the role of float

The College of Nurses of Ontario (CNO) states that while both RN and RPN study from the same body of knowledge, RPNs are more focused or have a basic knowledge foundation, whereas the RN have a greater depth and breadth of knowledge. When applying this standard, the major differences include: RPNs recognizing abnormal or unexpected changes in the client responses, whereas RNs can anticipate and prepare for possible outcomes by analyzing all influences.

RNs can also identify a full range of options based on their depth and breadth of knowledge, as well as analyzing and interpreting any unusual responses of the patient. RN’s apply a more global approach to solutions based on their knowledge of a variety of frameworks and theories vs. the RPN which is a

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7 CHSRF, 2006
8 HHR, Demonstration Project RN/RPN Utilization Toolkit, 2009
9 CNO, Professional Standards, revised 2002
more focused approach. As a result of this difference in the foundation of knowledge, the clinical expectation and level of autonomous practice for RNs and RPNs are different.

Both sites are considered high volume and high acuity as outlined in Table 9.

Table 9: Percentage of CTAS 2 and 3 patients at Church and Finch Street sites

<table>
<thead>
<tr>
<th></th>
<th>CTAS 2</th>
<th>CTAS 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church Street site</td>
<td>25%</td>
<td>62%</td>
</tr>
<tr>
<td>Finch Street site</td>
<td>25%</td>
<td>52%</td>
</tr>
</tbody>
</table>

The Canadian Nurses Association (CNA) emergency nurse’s certification, consist of competencies of a fully competent practicing emergency nurse with at least 2 years experience. They were developed as a result of the standards of practice developed by National Emergency Nurses Association (NENA). These specialty standards include professionalism/qualifications, practice, education and research. The competencies by the CNA provide guidelines for the RN practice and are recognized by the CNO. The Emergency Nurses Association of Ontario also provides and develops standards of practice for RN’s and provides ongoing learning and education. To date there are no competencies for RPNs working in an emergency department.

Within the emergency program there are thirty-eight (38) medical directives for the purpose of improving patient flow through the department by ensuring early institution of diagnoses and treatment. Some are initiated at triage, while others are initiated once the patient is in an area within the department. RNs can initiate and RPNs can implement these directives following signature of the RN. Therefore, the RPNs must be aware of their own scope of practice or comfort level as there may be parts of the directive which they may require transfer of care to the RN. Further to the directives the RPN, based on their scope of practice and job description as it relates to IV therapy are not to mix/hang any medication additives or blood products. The RNs throughout the hearing verbalized, to the IAC that a significant amount of time was spent as a result of RPNs locating RNs to sign the directive or transfer care in part or full. When a RN is already assigned a full workload, activities of this nature, while in the interest of patient care do increase their workload. The workload manifests itself in taking away direct care time with their assigned patients to care for the RPNs’ patients in full or part or the reassignment of the RPN to a more appropriate patient. Further to this there is the potential for delays in patient care as the RPN takes time to locate or wait for a RN to sign the directive. While this process involves 5 or 10 minute activities intermittently throughout a shift, it is the accumulative impact which can contribute to prolonging the duration of a patient’s overall length of stay in the department.

Recommendation 12: Regarding the Three-Factor Model the IAC:

1. In the absence of role clarity and clearly understood thresholds for transfer of care, an all RN staff in the Ozone area may be more efficient.
2. If the RPNs are to remain in Ozone the IAC recommends the Hospital explore a model of care that utilizes the role as a ‘care partner’ with the RN.
3. Supports the continued use of RPNs in Minor Treatment when the patients accessing care are CTAS 4s and 5s.
4. The minor treatment should also be evaluated when reviewing skill mix (see Recommendation re NP)
5. Sees a continued role for the RPN in the provision of care for admitted patients who are stable with a defined plan of care.

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10 OHA, 2006
Role of the Three-Factor Framework

While it was evident to the IAC that the model of care introduced intended to match the RPNs to patients with the most predictable outcomes, this has not worked as effectively as anticipated to date. As well, the IAC found that there was insufficient evidence of application of CNO’s 3 Factor Model in determining the work assignments of the RPNs. In addition, the lack of role clarity and scope and the perceived engagement in the process all contribute to the challenges.

The Hospital’s position is that RNs and RPNs study from the same body of nursing knowledge and according to the College of Nurses, this is correct. However, the RN and RPN Practice: The Client, the Nurse and the Environment \(^{11}\) also states that RNs study for a longer period of time, allowing for greater foundational knowledge in:

- Clinical practice,
- Decision-making,
- Critical thinking,
- Leadership,
- Research utilization and
- Resource management.

As a result of these differences, the level of autonomous practice of RNs differs from that of RPNs.

The Hospital, the Association and their Emergency RNs members appear to have approached the concept of patient stability / predictable outcomes from two different and distinct paradigms. The IAC believes that this situation developed because of a differing interpretation of the CNO Three-Factor Framework analysis. This situation was further compounded by the reliance on agency nurses, who are usually unfamiliar with the environment (an element of the Three-Factor Model).

In undertaking the assignment of a patient to a RN or RPN, one should review the Three-Factor Framework of the College of Nurses of Ontario (2011). The three factors serve to assist both nurses and employers in the decision to utilize individual nurses to provide safe care to all patients. The factors are:

1. The client
2. Nurse, and
3. The environment

Consideration of the three factors are especially important within the emergency department setting even when there is an established pattern of volume and acuity. Both emergency departments have high volume and acuity with rapid turnover. There is also the potential of a fluctuation in the stability of the patient requiring care, especially those higher acuity patients.

Aspects of complexity which affect patient assignment include:

- The degree to which the client’s condition and care requirements are identifiable and established
- Sum of the variables influencing a client’s current health status
- Variability of a client’s condition or care requirements\(^{12}\)

\(^{11}\) RN and RPN Practice: The Client, the Nurse and the Environment, College of Nurses of Ontario, 2011
\(^{12}\) CNO, RN and RPN Practice: The Client, the Nurse and the Environment. 2011
The higher the acuity or CTAS score, the more complex the patient. As Ontario's population demographics change, for example by 2031, 25% of Canada's population will be over age 65. Proportionately, more patients in Ontario will have complex multi-system diseases and are being seen in emergency departments. The implications of an aging population include increasing patient complexity. In the Central LHIN in which the hospital is situated, 42% of the population are aged 65 and older and have two or more chronic diseases. The community served by the Hospital has projected over the next 10 years the growth of people over the age of 65 will be 57%. The older the patient the more health problems and the more complex a patient becomes (LHIN, 2005). Also a good proportion of patients are immigrants and visible minorities and although there is lower than average conditions such as heart disease, blood pressure, asthma there is a higher than average rate of COPD and diabetes within this population.

In contrast, an example of a less complex patient would be where after triage by a RN, the care needs are well defined, coping mechanisms and supports in place and the presenting condition is well controlled. Given this the assignment of a RPN would be appropriate.

Predictability is the extent to which a client's outcome and future care requirements can be anticipated, all of which need to be considered prior to a RPN autonomously caring for the patient.

It would be difficult to assume patients in the emergency are predictable without having an in-depth assessment as per triage guidelines (caep.ca/resources/ctas/implementation-guidelines). The guidelines outline a more complete assessment and reassessment based on the category assigned to the patient. One must remember triage is a quick assessment to determine the acuity of the patient. The IAC heard that the nurses are aware of these guidelines as well as the reassessments of patients, but are having difficulties meeting these requirements. RNs stated that they have been told to do only a focused assessment in the Ozone area. These types of assessment will only focus on the chief complaint and may not provide enough information to determine predictability. RPNs undertake more of a focused assessment under their scope of practice, which is considered appropriate for patients who are less complex. Finally the risk of negative outcome, which is the likelihood that a patient will experience a negative outcome as a result of the patient's health condition or response to treatment, will aide in predictability. Taking all these factors into consideration about clients presenting in the emergency room is one determining factor for skill mix. Patients are not assigned to a RN or RPN, as on a unit. Picking up a chart is insufficient as a sole assessment to determine the complexity of a patient.

Given the above demographics it is critical that the application of the Three-Factor Model be done with care and in the context of the presenting volume and acuity of patients presenting on a daily basis.

Although a pattern of CTAS scores can be well established throughout the 24 hour day the assignment may still be problematic unless there is absolutely clarity with regard to the RPN scope as well as the threshold for transfer of accountability.

The RNs in both sites can practice autonomously in all situations and care for patients regardless of the complexity of the presenting patient. The RPN is more autonomous when caring for less complex patients with less complex conditions. The more complex a patient, the more that RPNs need consultation and collaboration with a RN. The RNs throughout the hearing stated they are frequently consulted by the RPN throughout their shifts and are having to have care transferred to them due to the complexity of the patient. In the absence of a defined care partner model, the lack of clarity with respect to above could ultimately cause care delays.

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13 Central LHIN, 2005

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Environmental factors include:

- Practice supports,
- Consultative supports and
- The stability/predictability of the environment

The less stable the environment factors are, the greater the need is for RNs to assume care for the patients. The less available practice supports and consultation resources are; the greater the need for more in-depth nursing competencies and skills in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resources management. These include clear policies, assessment tools and pre-developed care plans. The Hospital does have policies, job descriptions for all care providers, but there are no pre-developed care plans outlined. The stability/predictability of the environment also requires a high proportion of expert nurses available for consultation if required. Given 33% of the RNs have less than 3 years experience in parallel with significantly high agency utilization (see Recommendation 7) the consistent scheduling of sufficient numbers of expert nurses would be challenging. In the Church Street emergency department there are 27 RNs with less than 3 years experience and at the Finch site, 23 with less than 3 years experience. The IAC noted situations where junior/agency staff were working without sufficient expert nurses was documented several times on the professional responsibility workload forms in addition to being commented on by nurses during the hearing.

Similar to scenarios regarding RN workload described earlier in this section, working with an increased number of junior staff has a similar stressor impact. While the IAC notes that there are mentors at each site to assist junior staff with moving forward in their experience, they are small in number (see Recommendation 20 and Table 12). Also the volume of nurses who are not as familiar with the environment also impacts the workload pressures. For example, the IAC reviewed documentation and also heard during the tour and the hearing that the high utilization of agency nurses or float nurses limits the number of RNs with whom the RPN may consult with.

According to the CNO’s Three-Factor Framework RPNs and RNs can practice independently when there are less complex patients, the environment is stable and there are many practice supports and resources available. RPNs and RNs may collaborate when the client needs are moderately complex, environment moderately stable and predictable and has some practice supports. When patients become highly complex, environment becomes less stable and/or predictable, the RN can practice independently whereas the RPN cannot. If any of these areas change than there would be the need for a reassignment of category.

In summary,

1. Patients are triaged to an area in the emergency program, based on certain criteria.
2. When patients are sent to Ozone or fast track, they are not sent to see a specific discipline (RN or RPN). Until a further assessment is done, it would be difficult to assume pt is within the RPN scope of practice, as several other factors and discussed earlier are required to make that assessment.
3. Both Church and Finch Street sites have high acuity volume, more complex patients and the environment is unpredictable. The CNO clearly states if one of these factors is missing, that care must be with a RN.

Given the ongoing unpredictability of the CTAS 2 and 3 patients which access care by means of the Ozone area the IAC recommends that an all RN model may realize efficiencies if the RPN is going to be assigned to patients where there is an ongoing need for consultation, collaboration and ultimate transfer of care.

14 CNO, RN and RPN Practice: The Client, the Nurse and the Environment. 2011

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Recommendation 13: Immediately clarify the role of the physician assistant in relation of the Registered Nurse

The IAC was concerned that there was no clear delineated relationship between the RN and the role of the PA and this was consistent across both sites. Further to this, the IAC consulted the College of Nurses, Ontario and the following has been copied from their website.

Working with physician assistants

What is the role of physician assistants in relation to nurses?
Physician assistants (PAs) are unregulated care providers (UCPs) who provide medical services under the supervision of a physician. The PA's role is defined by the PA's competencies, the supervising physician's area of practice, and regulations governing the practice setting. Examples of duties that a PA may perform include conducting patient interviews and taking medical histories, performing physical exams, performing certain controlled acts as delegated by a physician and providing counseling on preventive health care.

Since PAs are UCPs, they do not have access to controlled acts. They can, however, perform controlled acts if they are delegated to them from a physician or anyone who is authorized to perform the controlled act. Since the PA has been delegated the authority to perform the controlled act, the PA cannot further delegate the act to nurses. Nurses cannot accept an order or delegation to perform a controlled act from a health care provider who does not have access to controlled acts.

If the procedure is not a controlled act, then whether a nurse may implement the order depends on the organization policy and legislation that is relevant to the practice setting. As always, nurses should use their judgment and ensure their practice is consistent with College standards.16

Further to the above, in conversation with and subsequent e-mail from Margo Bonathan, Professional Practice Department, College of Nurses of Ontario dated Tuesday February 12th 2013; she confirmed that Nurses (inclusive of RNs and RNPs) are not to action orders given by physician assistants. (Attached as Appendix 6). An order must come from the Physician as opposed to by means of a physician assistant.

Recommendation 14: Revisit the value of the role of a Nurse Practitioner in Minor Treatment

While the Hospital has made the decision to not incorporate the role of a Nurse Practitioner within the emergency department, the IAC recommends that they revisit the value add of the introduction of a Nurse Practitioner in Minor Treatment to increase throughput and eliminate overflow into the Ozone area.

Recommendation 15: Employ a long term recruitment and retention strategy for the Program

This strategy would include:
  a. A forecasting model (updated quarterly);
  b. Annual performance;
  c. A formal mentorship program (see Recommendation 20);
  d. Provision of ongoing education i.e. triage certification etc; and
  e. Undertaking an exit interview process. (see Recommendation 9)

16 College of Nurses, Ontario, website page last reviewed July 25, 2012
The IAC recommends that the Hospital builds on their existing Human Resources retention and recruitment program to embrace forecasting staffing needs beyond the budget year and implements strategies for recruitment and retention of these specialized nurses.

The IAC noted that the Hospital feels that the new hospital site will serve to attract RNs to the Program, and while they are correct; the IAC indicated their concerns with reliance on this strategy in the absence of strategies to up-skill staff and reduce both the utilization of agency nurses and overtime.

Costs of high turnover in an area which requires extensive orientation and precision balancing of novice and experience are astronomical over time. The literature has been known to cite recruitment in a specialty area such as emergency costing upwards of $35,000 (.5 FTE) per employee when labour costs of hiring, training etc. are all included.

The IAC acknowledges that the Table 10 below is an estimate only based on the LMR of active headcount at the end of each calendar year. The IAC also recommends that the Hospital continue to build on their recent progress in undertaking completion of performance appraisals. While there has been significant progress made in the last year, the annual volume undertaken still remains at only approximately 30% of the total number of RN FTEs.

Performance appraisals are used as a tool and should not be stressful for either the nurse or the manager. They should provide constructive opportunities for staff to discuss personal goals and concerns surrounding the workplace. They can be used as a positive approach to communication and to motivate and encourage staff. They can also be used to support nurse to become reflective in his/her practice, to review learning needs and receive feedback. Staff should be allowed to use this time to advocate for quality practice improvements. Both the manager and the nurse should be open, honest, use constructive feedback and mutual respect (service Canada, 2011). These performance appraisals in of itself can establish a climate of trust which is conducive to a good working relationship.

Table 10: Number of Performance Appraisals Completed

<table>
<thead>
<tr>
<th>Year</th>
<th>Church # Completed</th>
<th>Finch # Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>2011</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>22</td>
<td>17</td>
</tr>
</tbody>
</table>

Recommendation 16: Agency reduction strategy – involve the front line staff in developing and achieving the goal of zero

The IAC understands the Hospital’s decision to utilize nursing agencies into the staff mix in order to ameliorate the staffing shortage in the emergency departments due to unforeseen absences inclusive of both personal and last minute sick calls. To date as of November 2012 (8.68 FTEs) which if extrapolated, is likely to rise upwards of (13.02 FTEs). The IAC found the number of FTEs representing agency utilization especially high and in today’s fiscal climate, not sustainable.
Table 11: Agency Nurse Utilization for Emergency Church and Finch Street sites as a cumulative FTE budget YTD November 2012

<table>
<thead>
<tr>
<th>Site</th>
<th>Position</th>
<th>Hours</th>
<th>Equivalent FTE</th>
<th>Extrapolated to Year End March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church</td>
<td>Agency RN</td>
<td>7,949</td>
<td>6.09</td>
<td>9.14</td>
</tr>
<tr>
<td>Finch</td>
<td>Agency RN</td>
<td>3,377</td>
<td>2.59</td>
<td>3.88</td>
</tr>
<tr>
<td>Total</td>
<td>Agency RN</td>
<td>11,326</td>
<td>8.68</td>
<td>13.02</td>
</tr>
</tbody>
</table>

In the context of the data shared by the Hospital while there have been improvements, the Agency utilization is trending upwards behind overtime.

Table 8:

The Agency and overtime data provided to the IAC was extrapolated until the end of the 2012/13 budget year for the purpose of Table 8. Agency nurses are not a straightforward solution to augment staffing. They are not Hospital employees and therefore cannot assume full responsibility for patient care as they do not have full access to the Hospital computer system and therefore utilize paper documentation resulting in the patient record being a mix of multiple methods of communication. Responsibility for these patient care requirements therefore default to the Hospital RNs which can result in further increasing workload.

Recommendations 17: The IAC strongly recommends that there be a reconciliation of vacancies against budget

Upon review of the budget vs. actual hours alongside the vacancies provided by the Hospital’s Human Resources department there is a definitive discrepancy and this needs to be reviewed.

Upon reviewing the budget FTEs presented by the Hospital, the addition of an RN/24 hrs at each site is within the funding envelope and will help in reducing the vacancies. The assignment of this RN could be utilized wherever needed within the department, using Ozone as her/his base.

Recommendation 18: Training - through competency/skills review - staff self assessment. Resource Nurses and Managers undertake an assessment – develop a learning plan for all staff and link to performance improvements and align with CNO QA program. This recommendation is not clear at all; need to shorten and focus.

Following the implementation of the RN/RPN skill mix there was no evidence to support that the RN staff who hold or assume the role of the Triage/Charge/Resource Nurse were provided with additional education that would equip them to undertake the assignment of appropriate patients to RPNs. The educational material for the Charge Nurse and those RNs who routinely assume this role would serve to provide an opportunity to enhance their critical thinking, decision making and leadership skills.
The development of charge nurse education by means of formal programs are increasingly commonplace within organizations and can be supported with annual refreshers for existing as well as new RNs who become able to assume this role.

Recommendation 19: Implement education based on the assessment of learning needs

It is important for all nurses to receive regular formalized education to ensure that there is a common understanding regarding the expectations of their role and other roles within the new model of care. Specifically, they need to understand how the role of the RPN can effectively participate in the delivery of patient care on a day to day basis.

In addition staff need to receive education on new and existing policies to ensure consistent application. This includes:

- Mentorship programs;
- Annual Triage refresher courses;
- Certifications in ACLS, ATLS, PALS; and
- Others as identified through staff consultation.

Once learning needs have been identified for the staff, it is important that staff are provided the time to attend these courses or programs.

Recommendation 20: Increase the number of nurse mentors for new or returning nurses (RNs and RPNs)

Mentorship in nursing is well established. Florence Nightingale used a mentor style program to promote the concepts and philosophies that she espoused (Tucker-Allen et al 1992; Steele and Baker 1992). The partnerships that Nightingale encouraged between qualified nurses and trainees were based on caring, sharing, support relationships (Tucker-Allen et al 1992).

The IAC sees an opportunity for the Hospital to increase the number of RN nurse mentors who have completed a formal mentorship program. Given the specialized nature of emergency, all new nurses need to have a formalized mentorship plan to compliment the orientation program and ensure a smooth transition to an independent patient assignment. All new nurses at the end of their orientation program need to be assessed to determine if they need to have a formal mentorship plan put in place to facilitate optimization of their clinical practice, with a focus on goal achievement.

Recommendation 21: Adjust individual staffing assignments to accommodate for the orientation mentoring of new staff who are on or have completed orientation

The IAC would like to reinforce that a review of the literature widely reaffirms that, individual staffing assignments need to be adjusted to accommodate for the orientation needs and mentoring of new staff who are on or have completed orientation.

Recommendation 22: Provide an opportunity for ongoing evaluation of the mentoring process by both preceptors and mentors

There is a need for the Hospital to provide an opportunity for ongoing evaluation by mentors as well as preceptors of the mentoring experience in order to deal with success and issues as they arise.
CHANGE MANAGEMENT

A change management model provides both an organization and its staff with a structured approach to the need for, implementation and evaluation of a change. Every step of a change initiative is carefully constructed to enable the organization to create capacity for staff to assimilate the need for and operationalized readiness for implementation and subsequent evaluation.

When the Hospital was asked by the IAC what change management model has been utilized to implement the new model of care and in particular within the Ozone area, the IAC heard that a Plan Do Study Act (PDSA) approach had been employed. While the IAC appreciates that the value of a PDSA approach in relation to the magnitude of change, a PDSA is not synonymous with a structured change management framework. In response to further probing by the IAC, the Hospital shared what the IAC describes as a Leadership Development Model (see Appendix 5). The IAC asserts that this approach falls short of the structure required for the planning, implementation and evaluation of a change in skill mix and processes within both the Church and Finch Street emergency department sites.

Recommendation 23: Adopt and utilize a formalized Change Management Framework

There are substantive benefits to an organization and its employees in adopting and utilizing a formalized change management framework such as Kotter model (1995) which is used widely in both private and public sector organizations. Kotter is suggested as an illustrative model as it is only one framework or approach. The issue at hand is the use of a structured framework or approach for the change process.

The philosophy behind the Kotter theory in managing change is:

"The fundamental purpose of management is to keep the current system functioning. The fundamental purpose of leadership is to produce useful change."

When there is to be a change in model of care and or skill mix it should be approached as a method of organizational change which requires careful planning, communication, implementation and evaluation if it is to achieve its intended objectives.

PROCESSES

There are a number of processes that warrant consideration and attention; these include: use of a code bed and the management of internal emergencies; EMS offload; triage; bed allocation and management of the discharge process/ALC; change management; lean; use of professional responsibility forms and escalation process for accessing additional or replacement staffing; and others.

Code Bed

Recommendation 24: The Hospital immediately cease the practice of having the Emergency Department house the designated ‘code’ bed for an inpatient post resuscitation when an ICU bed is unavailable.

The IAC was surprised to learn that the emergency departments are required to house the designated ‘code’ bed for an inpatient post resuscitation when an ICU bed is unavailable as this is not considered optimal practice. The principle of getting the most appropriate care setting for the patient was the basis of this recommendation and it will also have a positive impact of the workload on the RNs within the Emergency Departments.
Other strategies which would serve to create capacity to treat and stabilize the patient in the most appropriate environment may include and which may be able to be adopted more immediately include:

- Identification of an ICU transfer out at the beginning of each shift; and
- Adjust staffing in ICU to accommodate organizational needs.

This creates capacity to treat and stabilize the patient in the most appropriate environment.

**Recommendation 25: Internal Emergencies and Intubated Patients Requiring Critical Care should be addressed through the organizational critical care capacity plan**

The Committee recognizes the practice of sending in-house intubated patients (i.e. patients who deteriorate and subsequently require critical care support) to the emergency department. This practice contributes to workload concerns and the perception of a 'chaotic' work environment. The Committee recognizes that both sites have physical capacity constraints in their critical care areas and that a critical care satellite facility already exists on the Finch Street site. There are significant physical plant limitations that have led to the practice of sending patients to emergency for care. While some hospitals resort to this practice when all other options have been exhausted, it is not considered optimal practice. Ideally, the critical care patient should be cared for in a critical care environment with the right staff and infrastructure.

While the Committee recognizes that the organization has an obligation to care for its own internal emergencies, we recommend that consideration be given to expanding critical care capacity in satellite locations in order that the appropriate staff can be secured and that the impact on the emergency department and its staff be minimized. Critical care patients residing in emergency that are expected to remain there with little option of securing a bed should be considered for Critical.

**Recommendation 26: Explore the development of a Critical Care Response Team within six (6) months**

The IAC recommends that Hospital explore the development of a Critical Care Response Team (CCRT) as they have the potential to significantly and positively impact critical care resources by bringing specialist knowledge and skill directly to the bedside 24/7. CCRT’s are comprised of a team of clinicians who provide critical assessment and management expertise wherever and whenever required. Leadership typically comes from an intensivist and the team is comprised of physicians, nurses and respiratory therapists who have special training. Functions include rapid critical assessment, management and follow-up, front-line education, follow-up on ICU discharges including medication reconciliation, care continuity and detection of early signs of deterioration.

The goals are to improve patient outcomes and safety and efficiency of resource utilization and would include:

- Reduced ICU readmission rates;
- Reduced code blue rates;
- Improved Hospital Standardized Mortality Ratio (HSMR) HSMR;
- Early intervention in situations of deteriorating patient status;
- More timely ICU admissions;
- Decreased lengths of stay; and
- The facilitation of knowledge transfer and teamwork to support the plan of care.

In many organizations the CCRT has contributed to reductions in Hospital mortality. Anecdotally, staff and physicians report increasing levels of confidence and security with respect to the early identification and intervention in deteriorating patient medical status and pre-code situations. The Committee suggests that a CCRT model would contribute to a reduction in the workload stress experienced by the emergency staff. The committee recognizes that CCRT funding models have
changed and that funding would need to come from internal resources with a resultant impact elsewhere within the organization. A commitment to initiate a CCRT would require an incremental resource commitment year over year however, the impact to quality and safety is worthy of serious consideration.

Recommendation 27: Off load nurse position to be staffed with an RN

Since 2008, the Ministry of Health and Long Term Care (MOHLTC) has funded the Offload Nurse Program. In August 2008 the program provided dedicated nurses to accept care of patients brought to hospital by paramedics. The IAC confirmed with EMS that the ‘Offload Nurse’ role is funded for an RN. Therefore, the IAC strongly recommends that the ‘Offload Nurse’ role is to be filled by a RN 100% of the time.

Recommendation 28: The offload nurse to assume the role of triaging the patient

Building on recommendation x concurrent to up-skilling the RNs in areas such as triage, the IAC recommends that the RN Offload Nurse undertake triaging the patient upon transfer from the EMS personnel. This would serve to create a win-win situation for all parties. EMS crews could get back on the road faster by facilitating the offload process in a more timely fashion and it would simultaneously reduce the burden on the triage nurse.

Recommendation 29: Increase the number of RNs who can assume the role of Triage and Mentor

The IAC noted from the information shared that there is opportunity to increase the Triage and Mentorship capacity within the existing RN complement of staff. Specifically, Table 12 below illustrates the

| Table 12: Nursing Staff Mix January to October 2012 |
|-----------------|--------------------|----------------|--------------------|
| Site            | Charge             | Triage          | Resus             | Mentor          | Novice < 2 years |
| Church n=72     | 26 (36%)           | 35 (48%)        | 54 (75%)          | 11 (15%)        | 18 (25%)         |
| Finch n=62      | 26 (42%)           | 36 (58%)        | 44 (71%)          | 11 (18%)        | 16 (26%)         |

Given the above table, the IAC recommends that the following:

1. Triage certification be increased from 48% and 58% respectively to 75% representing an increase in collective capacity for both sites by 17 RNs
2. Mentor capacity be increased from 15% and 18% which represents an increase in collective capacity for both sites by 17 RNs (those who have currently completed the mentorship program).

The IAC recognises that the 17 RNs may be certificated and or up-skilled in both or either Triage or Mentorship as appropriate.

The increase in Triage certification would also support implementation of Recommendation 29

Recommendation 30: Discharge process improvements and ALC reductions

The IAC both recognizes and commends efforts to improve patient flow and wait times, reduce length of stay and reduce alternate level of care (ALC) days with initiatives such as ‘There’s no place like home’ and other initiatives. These are important process changes and should continue. Use of other flow improvement tools such as Medworx can be helpful to optimize the process. Medworx is particularly useful because it supports the flow improvement strategies by identifying ‘readiness for discharge’ based on a validated instrument and is applicable to many patient settings. It provides the
hard data or evidence that is often required to substantiate care transition decisions and replaces the emotional dialogue about patient readiness for discharge by replacing it with quantifiable data. Data produced by the tool reduces the disputes among clinicians and creates more objective dialogue among the interdisciplinary team with respect to discharge planning. The IAC recognizes that the Hospital utilizes Medworx currently.


The IAC encourages the Hospital and the Association to utilize the Professional Responsibly Workload Report Forms (PRWLFS) as a source of data and opportunities for learning and identification of knowledge gaps.

Recommendation 32: Escalation process/algorithm for accessing additional or replacement staff

During the hearing the IAC heard conflicting interpretations of the escalation process/algorithm for accessing additional or replacement staff. The IAC recommend that the leadership team, in collaboration with staff, reviews and communicates the algorithm for calling in additional and/or replacement staff to ensure that there is consistent understanding of the process/protocol by all parties in the emergency departments at both sites. This approach will provide a solid basis for expectation management among the staff, the emergency department managers and the senior leadership team. It is also recommended that the managers review the budget objectives and targets as part of this process in order that the staffs are aware of the constraints and can integrate this information into their decision-making.

Access to additional or replacement staffing is cited as a frequent concern in the healthcare environment. This concern may be exacerbated by last minute changes in staffing due to unplanned absences such as sick calls or other unplanned events. In areas with significantly fluctuating capacity demands such as the emergency department, it can add to the frustration levels of team members and their respective workload. In particular, when a replacement team member is from an agency or another department and is therefore unfamiliar with the work routines and processes (e.g.; equipment; computer systems; medication delivery; and other systems) it compounds workload demands.

The escalation process for calling in and/or replacing staff is not clearly and consistently understood. The leadership team articulated the process and approach as set out in the algorithm for decision-making; staff however, conveyed that they were of the belief that they must obtain approval from their manager/designate who in turn then must get approval from one level up. Both the managers and the Vice Presidents indicated that this is not required. Calling in of staff should be done by the unit clerical assistant, which would relieve the nurse in charge to continue her/his own nursing duties. Clarification of both the algorithm and the escalation process will serve the departments well. Many organizations cite increased satisfaction and relationship building when front-line staffs believe that they have the control to manage these issues and that they will be supported by their leaders regardless of the decision. It has also been found that staffs are respectful of fiscal pressures and constraints and incorporate this willingly into their decision-making. In most cases staff is respectful of constraints and will alter their decision-making accordingly.

The IAC was also made aware of the Hospital’s work regarding a Critical Care Float Pool which could also be utilized to support the resuscitation areas or ICU admitted patients in the Church or Finch Street sites.

Recommendation 33: Lean: building on ED-PIP work

The Committee recommends that the organization build on the work that is already underway or in progress that is related to the previous ED-PIP work.
Lean and other process improvements

Lean is a management philosophy derived mostly from the Toyota Production System however it reflects a set of principles that are based on fundamental themes that include waste reduction or elimination of non-value added activities. It is also known as continuous improvement and it focuses on the process as the key means of improving activities and functions. While the terminology and approach differs among organizations, the overall 'lean' approach has been adapted in the healthcare environment and is useful strategically to shift culture and create capacity to do more with less and tactically, to create needed efficiencies.

The IAC understands that the Hospital was involved in the ED-PIP process as were many Ontario hospitals. As well the Hospital has continued with various focused improvement activities across the organization and in the emergency departments. These include:

- Kaizens;
- Rapid cycle improvements
- Work levelling; and
- Error/mistake proofing and others.

The power of kaizen is that you engage the right people (i.e. the people who do the work). Those who do the actual work identify the problems, discuss trial potential solutions and then create a better way to do business within a few days. Since leadership presence is required to support the process, it presents a wonderful opportunity for relationship building.

‘Going to Gemba’ or going directly to where the work is done and can be observed is a key principle for understanding process improvement. Only by observing the process and asking the questions do we really begin to understand whatever it is that we need to address. Visual Management tells us how we are sustaining our improvements and is a way for staff to communicate the success/difficulties for each day.

Given that lean or quality improvement thinking is established within the organization and that there are a number of process improvement opportunities in the emergency departments, the organization would be well served to continue this in a structured and systematic way. This approach would also actively support operational readiness which the Hospital acknowledged is key with the imminent new site opening/transit. These opportunities may include but are not limited to: the triage process; Ozone criteria and related patient flow; review of process and patient flow in the minor treatment areas (CTAS 4, 5); management of in-house codes; work environment and work space organization; EMS offload process (the Committee recognizes that a Task Force has already been established for this purpose); discharge process improvements and ALC reduction strategies; and others.

Additionally, we would recommend consideration of other tools that have been shown to be particularly effective in the healthcare environment. These may include tools for problem-solving and root cause analysis, etc. Root cause analysis is a helpful tool to engage those working in the process to ‘drill down’ to get to the crux of the problem or issue at hand. This is important because many times the concern that is expressed or put forward may represent symptom(s) and not the actual problem.

SAFETY and SECURITY

A healthy work environment is a setting that maximizes the health and well being of the interprofessional staff in supporting quality patient outcomes and overall organizational performance.
Safety is defined as uninjured, out of danger; not involving risk. The nurses in both emergency departments expressed concerns surrounding safety. Violence in the workplace has been defined under Bill 168 of the Occupational Health and Safety Act (2009) as:

_The exercise of physical force by a person against a worker, in a workplace that causes or could cause physical injury to the worker_

There is no control of the number or types of patients arriving in the emergency departments. But, it is important that staff, patients and their families feel safe when in the Church and Finch Street sites. Therefore, the management of violent patients is an important part of the nurses’ role.

The IAC observed that there was security on both sites 24/7. The staff stated that they do make frequent rounds and respond when called. The IAC also observed that the emergency is equipped with ‘buttons’ strategically placed for use when a nurse feels threatened or there is a violent patient.

The IAC was impressed with the usage of patient badges on the Finch Street site which are worn until discharge from the department. These when consistently used assist the staff if a patient leaves the department and should not have i.e. a mental health patient.

**Recommendation 34: The Hospital develop a program to ensure consistent implementation of the policy with respect to workplace violence**

The IAC sees the program inclusive of:
- Preparation of a policy with respect to workplace violence;
- Preparation of a policy with respect to harassment; and
- Review the policies as often as necessary.

**Recommendation 35: Annualize the staff training on the prevention of workplace violence and harassment**

The IAC was made aware of the required course for all staff on prevention of workplace violence and harassment, however, the IAC further understand that this was a one-time requirement. The IAC recommends that the training should be annualized.

With the nature of patients which present, specifically at the Finch Street site, these courses as well as the policies should be reviewed with all staff on a yearly basis. Accessing front line staff input would be an asset in dealing with these situations. Given it is important to attempt to diffuse the violence before it progresses and someone is harmed these courses do not include how to diffuse a violent patient, this should be provided to all staff.

With the assistance of the local occupational health and safety committee, the nurses in each emergency department site should undertake a physical assessment on a monthly basis to assess for any changes which may be required to reduce any harm from a patient to a staff member. Finally, security staff should be visible within the emergency department 24hrs/day.

**NURSE SAFETY RELATED TO FATIGUE**

Fatigue negatively impacts nurses and that in turn, may lead to moral distress. It can negatively impact physical and mental health. Several factors can cause fatigue; physiological, psychological,

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16 Webster's new dictionary, 1994

Independent Assessment Committee's report
Church and Finch Street sites of the Emergency Program, Humber River Hospital and Ontario Nurses Association
March 3rd 2013
behavioral and environmental\textsuperscript{17}. Fatigue can affect, both patient safety and nurse satisfaction, retention and personal safety.

There are several factors within the environment itself which contributes to fatigue. They include:

1. Increased workload;
2. Understaffing;
3. Increased expectations from patients and families;
4. High patient acuity;
5. Disorganized workplaces; and
6. Unexpected emergencies personal and professional\textsuperscript{18}

Other contributing factors for the potential for nurse fatigue at the HRH emergency rooms include but are not limited to:

- Overtime; (see Chart 1)
- Workload; and
- Inability to take scheduled breaks consistently through the work shift.

**Recommendation 36: Implementation of the RNNAO Best Practice Guideline to mitigate nurse fatigue in Health Care**

There are some factors which are beyond the control of RNs when working in any emergency room and include

- High acuity,
- Unexpected emergencies; and
- Increased expectations from patients and their families.

The RNNAO guidelines provide a variety of both organizational recommendations, and Team/Individual recommendations which the IAC feel would be useful for the nurses.

**Recommendation 37: Provision of constant care by staff other than base staffing**

The IAC noted documentation in the workload forms re: constant care patients. These patients are those who pose a risk to themselves or others. There is a Hospital policy for such patients. However it has been documented the availability to provide constant care is limited. In the policy the team leader/resource nurse will review and adjust the workload, to provide for the safety of patients. Once staff are assigned a constant care patient, this increases staffing issues within the department. Therefore the IAC recommends that the Hospital provide for the constant care of patients by means of alternatives to base staffing which may include:

- Constant care attendants pool; i.e. PSWs; and/or
- Security guards who could ensure containment, assuming appropriate de-escalation training

**PHYSICAL ENVIRONMENT**

The IAC understands and appreciates the current constraints surrounding the physical layout of both the Church and Finch Street sites.

\textsuperscript{17} CNA-Fact Sheet Nurse Fatigue, 2012

\textsuperscript{18} CNA - Taking Action on Nurse Fatigue, 2011
The IAC further realize the fiscal constraints in directing money into patient care areas which will be redundant within the next two years.

During the tours of each department site, the IAC did note the appearance of clutter in the halls. It has been documented on several professional workload responsibility forms that nursing undertakes care for patients within hallway settings and the two combines have the potential to present a safety/fire hazard, over and above the direct privacy issue.

Physicians and staff speak with patients regarding their reason for visit or treatment and the next patient or visitor coming up the hall can overhear their issues. A proper assessment or reassessment cannot be done in the hallway therefore nurses are unable to meet needs for confidentiality, privacy, infection control, patient dignity. These issues effect both staff and patients. The addition of hallway patients within an already chaotic and stressful environment ultimately increases the workload stress for staff.

The IAC heard that the Ozone area often cares for more patients than was originally planned, therefore placing in overcapacity. At the Finch Street site patients are placed in the hall area where they are out of view of the nurses who are working in the Ozone area. This has potential for a dangerous outcome, if patient status changes. Due to the high volume in both the minor treatment and Ozone areas in both sites as documented and verbalized by the staff it is recommended, once all designated treatment areas i.e. stretchers and chairs are occupied, if physician is behind on their assessments or if there is more than five (5) patients awaiting treatment, the nurse in the area may tightly control the flow in order to provide safe care to those within the area. The minor treatment area at the both sites will cease taking patients one hour before close; this will allow for staff to finish up and for the physicians to reassess and decide on disposition of patients. This may also reduce overtime.

Recommendation 38: Review and revise the surge capacity processes and protocols as per the suggestions below:

The IAC recommends that the following be given serious consideration to facilitate safe and sustainable surge capacity while minimizing the impact on RN workload:

1. When Church Street site’s Ozone is at or overcapacity, patients could be directed and cared for by the under-utilized CDU unit.
2. Health care aid provision of basic care for patients accessing care in a hallway, such as toileting, giving nourishments, etc.
3. Temporary location within the Hospital, or using beds for overcapacity on the inpatient units.
4. Explore the feasibility of resetting the guideline for initiating bed alert in the ED to include a lower admitted bed threshold plus other factors.
5. Transfer of patients to an inpatient unit be done as soon as bed available regardless of time of day.

Recommendation 39: SS and the physical environment

The SS is a derived from five Japanese terms beginning with “s” used to create a workplace suited for visual control and lean production:

- **Seiri** means to separate needed tools, parts, and instructions from unneeded materials and to remove the unneeded ones.
- **Seiton** means to neatly arrange and identify parts and tools for ease of use.
- **Seiso** means to conduct a cleanup campaign.
- **Seiketsu** means to conduct seiri, seiton, and seiso daily to maintain a workplace in perfect condition.
- **Shitsuke** means to form the habit of always following the first four s’s.
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<th>Japanese</th>
<th>Translation</th>
<th>&quot;S&quot; Translation</th>
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<tr>
<td>Selri</td>
<td>Cleaning/</td>
<td>Sifting</td>
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<td>Selton</td>
<td>Neatness/</td>
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<td>Shitsuke</td>
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Utilization of the tool creates an environment that allows work to flow, in a safe, organized, intuitive and sustainable way. To gain full benefit of the technique it should be approached as more than just a tidy up or spring clean, but seen as a way of providing systems and process with attached roles and responsibilities to improve work flow, supported by management.

The IAC recommends that the first priority should be a series of 5S activities in both emergency departments. 5S is a work space organizational tool that focuses on creating a safe work environment by reducing clutter and making sure that everything has a designated place. The IAC recognizes that leading practice in this area suggests that if work units are unable to sustain 5S changes, then they are unlikely to sustain other improvements. Staffs described their work environments as 'chaotic'. The Committee believes that the work environments, despite obvious physical plant limitations, are somewhat disorderly and cluttered and could benefit from improvement. Following successful sustainment of 5S (several in each site would be required), the organization should proceed to address other process improvements based on an engaged prioritization exercise.

Thoughtful engagement of the multidisciplinary team including representation from the staff members’ respective unions, will be a critical success factor moving forward. The use of lean tools offers a significant engagement opportunity and this is much needed. The basic concepts associated with lean appear to be understood and supported by the staff, physicians and the union; the IAC believes that this is an important precursor for success.

The IAC recommends that concurrent with a systematic review of staffing complements and scheduling in both sites, the organization must optimize departmental efficiencies prior to contemplating any significant staffing changes. As well, such efficiencies could have a positive impact on perceived workload.

**Recommendation 40: Access to equipment**

Staff repeatedly expressed concerns about the timely access to, and availability of basic patient care equipment including pumps, wheelchairs, stretchers and other items. While the IAC recognizes that the Hospital has recently purchased additional stretchers, the IAC recommends the Hospital give serious consideration to the development of a centralized equipment management and tracking process. Such systems usually relieve some of the burden associated with searching for equipment and the perception of increased workload stress which subsequently can ensue.

The Hospital should review the possibility of a UCP to provide day to day, shift to shift basic supports for patient needs.
Part IV SUMMARY and CONCLUSIONS

The IAC was requested to specifically address the issue that the workload complaint arising from the Hospital “assigning a workload to an individual RN and group of RNs working IN THE Church and Finch Street sites of the Emergency Program such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care”.

The IAC has made 40 recommendations following a comprehensive process involving review of written and oral presentations focused conversations, and ensuring discussion and clarification during the three (3) day hearing and extensive Committee analysis and discussion following the Hearing.

The 40 Recommendations address Communication, Staffing, Change Management, Processes, Safety and Security and the Physical Environment, a number of which are interdependent and are therefore referenced accordingly.

The IAC strongly believes that the Hospital and Association have a tremendous opportunity for a “fresh start”. The IAC also strongly believes that the process of implementing these recommendations will have a very positive impact on the relationship between the Hospital and the RN staff of both the Church and Finch Street sites of the Emergency Program which will have a cascading effect of improving the quality of the patient care, nursing workload, the RN staff working environment, and achieving full integration of the sites prior to the opening of the new consolidated service in March 2015.

The IAC encourages the Hospital and the Association to work together to achieve these recommendations, and to make effective use of data to evaluate their progress and leverage the ability to learn and adjust as appropriate along the way.
References


Appendices
September 27, 2012

Ms. Margaret Czaus
Chief Nursing Officer
Humber River Regional Hospital
2111 Finch Avenue West
Downsview, ON M3N 1N1

Dear Ms. Czaus,

Re: Professional Responsibility Complaint in the Emergency Department(s) – ONA Gel File Numbers – 201108538 and 201108539

The Registered Nurses of the Emergency Department(s), Humber River Regional Hospital (HRRH) have identified ongoing practice and workload concerns as evidenced by the data consistently submitted on numerous Professional Responsibility Workload Report Forms.

The Union is seeking resolution of the concerns on behalf of our members and the patients that they care for. To date the employer has been unable to propose or agree to sufficient measures to resolve the concerns. Timely resolution of the Professional Responsibility Company is vital to enable the RNs to deliver safe, competent and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee as per Article 8 of the collective agreement.

Please be advised that the Ontario Nurses’ Association nominee to the Independent Assessment committee is:

Cynthia Gabrielli
6285 McMicking Street
Niagara Falls, Ontario
L2J 1W7
Tel: 905-357-6276 (home)
Tel: 905-329-3597 (cell)
Email: cgabrielli@coceco.ca

Please provide written confirmation concerning the name, mailing address, home or cell and office phone numbers and e-mail address of your nominee. The name of the next Chairperson
on the list in Appendix 2, June Duesbury Porter, will also need to have the nominee information.

Sincerely,

ONTARIO NURSES' ASSOCIATION

Mariana Markovic

Mariana Markovic
Professional Practice Specialist

C: Cynthia Gabrielli, ONA nominee
Catherine Green, HRRH Manager Labour Relations
Barbara Willitts, HRRH Program Director, Acute Medicine and Emergency Services
Scot Jarrett, HRRH Vice President Patient Services
Rueben Devlin, HRRH President and Chief Executive Officer
James O'Sullivan, HRRH Board of Directors, Chair
Michael Howell, ONA Local Coordinator
Sheri Street, ONA Labour Relations Officer
Doug Anderson, ONA Manager Provincial Services Team
Stephen Green, Ontario Hospital Association
Pre-Hearing Meeting was held in Toronto on Thursday January 2\textsuperscript{nd} 2013, 1-2pm

The IAC reviewed the anticipated process of the Hearing and included an agreed request for additional information in selected areas from the employer

Request for additional information from the Employer includes:

Medical and EMS Leadership
- The IAC has identified the need to speak with the following personnel:
  - Chief of ED – present during the tour
  - EMS operations – preferably the morning of either January 15\textsuperscript{th} or 16\textsuperscript{th} 2013

Staffing data

*Base Staffing (Budgeted for 2011/12) by site and collectively as an ED program*

RNs
- # of FT
- # of PT

RPNs
- # of FT
- # of PT

Casual Staff available hours
- # of Casual RNs
- # of Casual RPNs

Allied Health (including FTE Social Work, etc)
- # of FT
- # of PT

*Vacancy Information as of January 3\textsuperscript{rd} 2013 – please separate out true vacancies and if there is a new hire to fill the current vacancy*

- # of vacant RN and their respective FTEs
- # of vacant RPN and their respective FTEs

*Allotted Support Staff – housekeeping, clerical, orthotechs etc. for both ED sites*

- Daily hours for weekdays and weekends of housekeeping, clerical, orthotechs etc coverage for unit
  - # of FT
  - # of Temp FT
  - # of PT
  - # of Temp PT
Actual Staffing (Headcount currently in place) by site and collectively as an ED program

RNs
- # of FT
- # of Temp FT
- # of PT (please also provide the FTE commitment of each PT person for RNs and RPNs)
- # of Temp PT

RPNs
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

Casual Staff available
- # of Casual RNs
- # of Casual RPNs

PSW
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

Allied Health (i.e. Social Worker)
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

Support Staff – housekeeping, clerical, orthotechs etc., FTEs and hours allotted per shift
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

Staff Scheduling
- Who does the schedule for the Church and Finch Street sites?
- Who has accountability for ‘filling’ the holes on the posted scheduled?
- Who has accountability for calling in replacement staff for Church and Finch Street sites (include both inside and outside of M-F daytime hours)

Vacation Allocations for RNs and RPNs (peak and off peak times)
- # of RNs allowed off during peak and off peak vacation times
- # of RPNs allowed off during peak and off peak vacation time
Human Resource Indicators and Information
- Number of RNs, RPNs with less than 1 years experience specific to ED, 1-3 experience specific to ED and greater than 3 years experience specific to ED in both HRRH and their career
- Sick time: sick rate/FTE for nursing within the HRRH, Emergency Program and by both Church and Finch Street sites
- Sick time for nursing within the HRRH, Emergency Program and by both Church and Finch Street as a cumulative FTE for budget YTD
- Overtime: OT rate/FTE for nursing within the HRRH, Emergency Program and by both Church and Finch Street sites
- OT for ED Program as a cumulative FTE for budget YTD
- Turnover: RN rate/FTE for nursing within the HRRH, Emergency Program and by both Church and Finch Street sites
- Casual Nurse utilization for Church and Finch Street sites as a cumulative FTE for budget YTD
- Float Nurse utilization for Church and Finch Street sites as a cumulative FTE for budget YTD
- Agency Nurse utilization for Emergency Program, Church and Finch Street sites as a cumulative FTE budget YTD
- Is there an annual performance review process?
- Number of RNs and RPNs in Emergency Program and respective Church and Finch Street sites currently on any kind of leave (e.g. MLOA, personal, education); those expected back to work in the next year (please specify FT or PT)
- Number of RNs and RPNs expected to go on a leave in the next year, in Emergency Program and respective Church and Finch Street sites (please specify if FT or PT)
- Number of RNs and RPNs in Emergency Program and respective Church and Finch Street sites expected to retire in the next year

Other Staffing Items
- Details of orientation arrangements with Agency supplying nurses to the FED or CED sites
- Guidance for the assignment of patients for Agency Staff

Float RPN
- Role of the Float RPN
- Job duties and responsibilities

Lab Work
- Hours when nurses draw patient blood work
- Hours when nurses do not draw patient blood work

ECG
- Hours when nurses take ECGs
- Hours when nurses do not take ECGs

Equipment available to each CED and FED sites
- # of IV pumps
- # of Automatic Digital Blood Pressure Devices
Staff Schedule – copies of each site’s

- Copy of Finch Street Site
- Copy of Church Street Site

Physician Assistant

- Job description
- Location of work
- Hours of work

CDU

- Utilization data
- Please clarify why patients are removed from the tracker when in CDU

Medical Directive

- Complete listing
- Who initiates them

Tab 17

The information notes that ‘blocks highlighted in yellow indicate some overlap of time during which the physicians is responsible for more than one area in the department – please provide in colour to enable identification of the areas of overlap. Further to this since Tab 18 is identified as the Finch Street Site, please confirm that this is for the Church Street site.

Tab 18

- The information notes that ‘blocks highlighted in yellow indicate some overlap of time during which the physicians is responsible for more than one area in the department – please provide in colour to enable identification of the areas of overlap.

Tab 19

- Please clarify Evening and night shift staffing where there is an *
- It is unclear as to the number of RPNs on 2330-0730 for both Church and Finch Street ED sites as the total columns indicate 2.75 and 2.5 respectively

Tab 21

Lines 51-63 of the pre-hearing submission have been blanked out – please re-provide or explain the rationale for the lines being blanked out.

Tab 22

First page within this Tab has numerous lines blanked out - please re-provide or explain the rationale for the lines being blanked out.
Appendix 2

Tab 37

- Please clarify and place in context
- Please clarify if there are in fact then 11 nurses who act as a mentor to new staff
- Please provide details regarding Mentorship at HRRH and the ED program and specifically Church and Finch Street ED sites
- Does the data represent all RNs?
- Please provide the nursing skill mix for the budget year 2010-2011

Tab 45

HRRH Daily Access Indicator Report – Summary Statistics, Church and Finch Street sites

- Please re-provide information as one within the pre-hearing submission has #REF in approximately 50% of the categories.

Tab 46

Given shading numerous cells are unreadable – please resubmit by soft copy or without shading

Tab 50

Please provide the anticipated and actual timelines for operational execution of the decision tree for both Church and Finch Street sites

Patient Profiles

- # of presentations over age 65

Patient Flow Data by CED and FED sites

- Presentation by hour over a 24 hour period for all and each CTAS
- CTAS by zone over 24 hours
- ALOS and Mean LOS for no bed admits
- Number of admissions and discharges by hour for last 6 months
- OR block times by day of week (designating if ½ or full days) for all specialties for last 6 months
- Avg and mean ED Census by Hour by Day 2011-12 and ytd
- CTAS ED Census visits by Hour by Day 2011-12 and YTD

Model of Care

- July 14th 2009 Rueben Devlin, President and CEO issued a memo for all HHRRH Staff and Physicians regarding ‘New Model of Care’ - please provide more detail regarding this model of care as the memo only seems to announce the hiring of approximately 80 diploma prepared RNPS and other laborer relations issues.
- Monday July 23rd Mayda Timberlake (CED) indicated that the nurses are working primary but as a team based approach – what is the model of care employed – please state and outline how it is operationalized:

Comparable Cohort

- Please provide your MOHLTC comparable cohort and the % of ED visits across them by CTAS 1 through 5

Off Load Nurse
• Monday July 23rd 2012 Barb Willis apparently identified that EMS has now provide funding to the Hospital to have RNs nursing in the Off Load areas – please outline what the funding supports in terms of designation required (RN vs. RPN), FTE, training etc.
  o Further to this please clarify if EMS has provided funding for RNs why a RPN is scheduled from 2330-0730 as per Tab 19
• Barb Willis further indicated that due to staffing shortages in the department RPNs are utilized in this area – please confirm and provide underlying rationale
• Further to the above, please outline how the additional 20 hours of RN coverage daily (2.5 FTE) has been fulfilled

New Development Finch Street ED Site

• There has been a noticeable absence of information, post construction dollars etc from the pre-hearing submission. Given the projected ED visits from the information available on the HRRH website, the IAC looks forward to receiving more information regarding this and hearing more during the course of the hearing.

ICU patients in ED

• Given not every ICU patient in ED is not a one to one – please outline how many RNs are required for an ICU patient – please indicated the process of identifying a patient as requiring ICU care

Surge or Overcapacity Protocol

• Please provide copies of the above for HRRH or for each site

Professional Development for Church and Finch Street sites respectively
• Staffing levels when in-service and educational opportunities are offered for last 6 months
• Schedule (including topics) of continuing education and in-service sessions for last 6 months
• Attendance at in-service and educational opportunities for last 6 months
• Description and number of RNs which have participated in the MOHLTC initiatives such as late career
• IV and other equipment training schedules for last 12 months

Emergency Program

• Leadership structure
• Last annual Emergency Program report to the Board and MAC

Patient Satisfaction

• Patient satisfaction data relating to HRRH, the Emergency Program and Church and Finch Street sites

Staff Satisfaction

• Staff satisfaction/quality of work life/engagement data/survey to nursing (by RN and RPN is available) within the HRRH, Emergency Program and by both Church and Finch Street

Administrative Information
Administrative Information

- Organizational chart for HRRH as a whole, and for the Emergency Program, Church and Finch Street sites.
  - Lines of accountability for operations and for professional nursing practice.
  - Medical leadership, site and program
- Manager’s span of control for Church Street ED site
- Manager’s span of control for Finch Street ED site

Quality and Patient Safety

- Adverse and critical incidents in last 12 months for HRRH, Emergency Program and Church and Finch Street sites respectively
- Medication incidents for HRRH, Emergency Program and Church and Finch Street sites respectively
- Medication incidents and information
- Volume of ‘near misses’ for HRRH, Emergency Program and Church and Finch Street sites respectively
- # Isolations for last 6 months
- Description of Quality/Continuous Improvement projects over the past two years relating to nurses and/or nursing practice for Emergency Program, Church and Finch Street sites
# Independent Assessment Committee Hearing Agenda

**Ontario Nurses' Association and Humber River Hospital**

**Tuesday January 15th 2013, Holiday Inn, 3450 Dufferin Street, Toronto**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30</td>
<td>Meet in Church Street ED site</td>
<td>J. Duesbury-Porter, M. Timberlake, B. Willitts, C. Green, S. Eves, S. Crumb</td>
</tr>
<tr>
<td>7:45 - 10:30</td>
<td>Tour of Church Street ED site</td>
<td>IAC</td>
</tr>
<tr>
<td>10:30 - 11:00</td>
<td>Caroline Mellor, Commander, Dedicated Offload Nurse Program at Toronto EMS</td>
<td>IAC</td>
</tr>
<tr>
<td>11:00 - 12:00</td>
<td>IAC (flexible time and travel time to Holiday Inn)</td>
<td>IAC</td>
</tr>
<tr>
<td>12:00 - 13</td>
<td>Lunch at Holiday Inn</td>
<td>IAC</td>
</tr>
<tr>
<td>13:00 - 13:10</td>
<td>Introduction and Review of Proceedings</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>13:10 - 14:40</td>
<td>Ontario Nurses' Association Submission Presentation</td>
<td>IAC</td>
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- Independent Assessment
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Committee</th>
<th>HRH Attendees</th>
<th>ONA Attendees</th>
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</thead>
<tbody>
<tr>
<td>14:40 - 15:00</td>
<td>Break</td>
<td>All</td>
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<tr>
<td>15:00 - 16:30</td>
<td>HRH Presentation</td>
<td>IAC</td>
<td>All HRH attendees (please see attachment)</td>
<td>All ONA attendees (please see attachment)</td>
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<td></td>
<td>Response to questions of clarification from</td>
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<td>• Independent Assessment Committee</td>
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<td>• Ontario Nurses' Association</td>
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<tr>
<td>16:30 - 17:00</td>
<td>Review of Process for early evening tour of Finch Street ED site and</td>
<td>IAC Chair</td>
<td>All HRH attendees (please see attachment)</td>
<td>All ONA attendees (please see attachment)</td>
</tr>
<tr>
<td></td>
<td>Wednesday January 16th 2013</td>
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<tr>
<td>17:00</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
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<tr>
<td>17:00 - 17:30</td>
<td>Travel Time</td>
<td>IAC</td>
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<tr>
<td>17:30 - 18:00</td>
<td>Meeting with Dr. Nalin Ahluwalia</td>
<td>IAC</td>
<td>M. Timberlake</td>
<td>S. Aikulola, M. Howell, S. Street, M. Markovic</td>
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<td></td>
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<td>B. Willitts</td>
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<td>S. Eves</td>
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<td></td>
<td></td>
<td></td>
<td>S. Crumb</td>
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</tr>
<tr>
<td>18:30 - 20:30</td>
<td>Tour of Finch Street ED site Dr. Nalin Ahluwalia (19:30 to 19:50 min</td>
<td>J Duesbury-Porter</td>
<td>D. Avgirinos</td>
<td>F. Ruggiero</td>
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<tr>
<td></td>
<td>Finch Courtyard Conference Room)</td>
<td></td>
<td>B. Willitts</td>
<td>T. Leathers</td>
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<td></td>
<td></td>
<td>Cynthia Gabrielli</td>
<td>C. Green</td>
<td>M. Howell</td>
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<td>Jo-Anne Marr</td>
<td>S. Eves</td>
<td>M. Markovic</td>
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Independent Assessment Committee Hearing Agenda
Ontario Nurses' Association and Humber River Hospital

Wednesday January 16th 2013, Holiday Inn, 3450 Dufferin Street, Toronto

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tbody>
<tr>
<td>07:30</td>
<td>Meet in Finch Street ED site</td>
<td>J. Duesbury-Porter</td>
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<tr>
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<td>C. Gabrielli</td>
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<td>Jo-Anne Marr</td>
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<tr>
<td>07:45 - 10:30</td>
<td>Tour of Finch Street ED site</td>
<td>IAC</td>
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<td>D. Avgieros</td>
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<td>B. Willitts</td>
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<td>C. Green</td>
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<td>S. Eves</td>
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<td>F. Ruggiero</td>
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<td>T. Leathers</td>
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<td>M. Howell</td>
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<tr>
<td>10:30 - 12:00</td>
<td>IAC (flexible time, travel time to</td>
<td>IAC</td>
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<td>Holiday Inn)</td>
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<tr>
<td>12:00 - 13:00</td>
<td>Lunch at Holiday Inn</td>
<td>IAC</td>
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<tr>
<td>13:00 - 13:05</td>
<td>Introduction and Review of</td>
<td>IAC Chair</td>
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<td>Proceedings by Chairperson</td>
<td>All HRH attendees</td>
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<td>(please see attachment)</td>
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<td></td>
<td>All ONA attendees</td>
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<tr>
<td>13:15 - 14:45</td>
<td>HRH Response to Ontario</td>
<td>IAC</td>
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<td>Nurses' Association Submission</td>
<td>All HRH attendees</td>
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<td>Response to questions from</td>
<td>(please see attachment)</td>
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<td>• Independent Assessment Committee</td>
<td>All ONA attendees</td>
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<td>• Ontario Nurses' Association</td>
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<td></td>
<td>• Discussion</td>
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<td>14:45 - 15:15</td>
<td>Break</td>
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Appendix 3
<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Chair</th>
<th>HRH Attendees</th>
<th>ONA Attendees</th>
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<tbody>
<tr>
<td>15:15 -</td>
<td>Ontario Nurses' Association Response to HRH Submission</td>
<td>IAC</td>
<td>All HRH</td>
<td>All ONA</td>
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<td>16:45</td>
<td>Response to questions from</td>
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<td>attendees</td>
<td>attendees</td>
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<td>• Independent Assessment Committee</td>
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<td>• HRH</td>
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<tr>
<td></td>
<td>• Discussion</td>
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<tr>
<td>16:45 -</td>
<td>Review of Process for Thursday January 17th 2013</td>
<td>IAC Chair</td>
<td>All HRH</td>
<td>All ONA</td>
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<tr>
<td>17:00</td>
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<td>attendees</td>
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<td>attachment)</td>
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<tr>
<td>17:00</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
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<tr>
<td>18:30 -</td>
<td>Working Dinner</td>
<td>IAC</td>
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<td>21:30</td>
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</table>
# Independent Assessment Committee Hearing Agenda

**Ontario Nurses’ Association and Humber River Hospital**

**Thursday January 17th 2013, Holiday Inn, 3450 Dufferin Street Toronto**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 - 9:00</td>
<td>Working breakfast</td>
<td>IAC</td>
</tr>
<tr>
<td>09:00 - 10:30</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>J. Duesbury-Porter</td>
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<tr>
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<td>C. Gabrielli</td>
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<td></td>
<td>Jo-Anne Marr</td>
</tr>
<tr>
<td>10:30 - 11:00</td>
<td>Break</td>
<td>All</td>
</tr>
<tr>
<td>11:00 - 13:00</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>J. Duesbury-Porter</td>
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<td>C. Gabrielli</td>
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<tr>
<td></td>
<td></td>
<td>Jo-Anne Marr</td>
</tr>
<tr>
<td>13:00 - 13:30</td>
<td>Closing Remarks and Identification of Next Steps by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>13:30</td>
<td>Closure of Hearing</td>
<td>All</td>
</tr>
<tr>
<td>13:30 - 16:00</td>
<td>IAC Meeting - Working Lunch</td>
<td>IAC</td>
</tr>
</tbody>
</table>
Ontario Nurses Association IAC Attendee List

Tour Attendee List

Finch Site:
Franca Ruggiero, RN, ER Finch Site
Tracey Leathers, RN, ER Finch Site
Michael Howell, BUP and LC Local 68
Mariana Markovic, Professional Practice Specialist, LRO, ONA

Church Site:
Samuel Alkulola RN, ER Church Site ONA Unit Rep
Valerie Wakefield, RN, ER Church Site
Michael Howell, BUP and LC Local 68
Mariana Markovic, Professional Practice Specialist, LRO, ONA

IAC Hearing Attendee List
Mariana Markovic, Professional Practice Specialist, LRO, ONA
Elizabeth McIntyre, ONA Counsel (*January 15th afternoon only*)
Michael Howell, RN, Local 051 - Bargaining Unit President, Local Coordinator
Sheri Street, Labour Relations Officer, ONA
Samuel Alkulola, RN, ER Church Site ONA Unit Rep
Tracey Leathers, RN ER Finch Site
Valerie McDonald, Manager, ONA (*January 16th afternoon only as an observer*)

RN Attending the Hearing/Observing:
Louise Howland, RN, Church Site
Valerie Wakefield, RN Church Site
Beata Zegel-Gelios, RN, Church Site
Joanne MacAluso, RN, Church Site
Franca Ruggiero, RN, Finch Site
Maria (Rina) Cherubino, RN, Finch Site

Observers/Learners ONA staff
Lorrie Daniels, PPS, LRO, ONA (Jan 15th afternoon only)
Karen Todkill, LRO, ONA
Barbara Worthington, LRO, ONA
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Green</td>
<td>Manager, Labour Relations</td>
</tr>
<tr>
<td><a href="mailto:cgreen@HRH.on.ca">cgreen@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Kelly Kimens</td>
<td>Director, Employee Relations and Occupational Health &amp; Safety</td>
</tr>
<tr>
<td><a href="mailto:kkimens@HRH.on.ca">kkimens@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Marg Czauš</td>
<td>Chief Nursing Officer &amp; Professional Practice; Finch Site Administrator</td>
</tr>
<tr>
<td>mczauš@HRH.on.ca</td>
<td></td>
</tr>
<tr>
<td>Scott Jarrett</td>
<td>Vice President, Patient Services</td>
</tr>
<tr>
<td><a href="mailto:sjarrett@HRH.on.ca">sjarrett@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Barbara Willits</td>
<td>Program Director, Acute Medicine &amp; Emergency Services</td>
</tr>
<tr>
<td><a href="mailto:bwillits@HRH.on.ca">bwillits@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Diana Avginerinos</td>
<td>Manager Emergency Services (Finch)</td>
</tr>
<tr>
<td><a href="mailto:davginerinos@HRH.on.ca">davginerinos@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Leanna Happy Macey</td>
<td>Clinical Practice Leader, Emergency Services (Finch)</td>
</tr>
<tr>
<td><a href="mailto:Imacey@HRH.on.ca">Imacey@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Mayda Timberlake</td>
<td>Manager Emergency Services (Church)</td>
</tr>
<tr>
<td><a href="mailto:mtimberlake@HRH.on.ca">mtimberlake@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Elizabeth Taylor</td>
<td>Clinical Practice Leader, Emergency Services (Church)</td>
</tr>
<tr>
<td><a href="mailto:eataylor@HRH.on.ca">eataylor@HRH.on.ca</a></td>
<td></td>
</tr>
<tr>
<td>Ad Hoc Member:</td>
<td>Vice President, Human Resources &amp; Organizational Effectiveness</td>
</tr>
<tr>
<td>Kevin Wilson</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:kwilson@HRH.on.ca">kwilson@HRH.on.ca</a></td>
<td>Hicks Morley LLP Legal Counsel to the Hospital</td>
</tr>
<tr>
<td>Sarah Eves</td>
<td>Hicks Morley LLP Legal Counsel to the Hospital</td>
</tr>
<tr>
<td><a href="mailto:sarah-eves@hicksmorley.com">sarah-eves@hicksmorley.com</a></td>
<td></td>
</tr>
<tr>
<td>Samantha Crumb</td>
<td>Hicks Morley LLP Legal Counsel to the Hospital</td>
</tr>
<tr>
<td><a href="mailto:samantha-crumb@hicksmorley.com">samantha-crumb@hicksmorley.com</a></td>
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</tr>
<tr>
<td>Stephen Green</td>
<td>Director, OHA (January 16th afternoon only as an observer)</td>
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LEADING PEOPLE THROUGH CHANGE
Humber River Regional Hospital
From: Bonathan, Margo [mailto:MBonathan@cnomail.org]
Sent: February 12, 2013 7:53 AM
To: 'June Porter'
Subject: RE: just an item I would like clarified please

Dear June: Yes the statement around the physician assistant is true. They are unregulated care providers and have no authority to order.

Margo Bonathan RPN
Practice Liaison
Professional Practice Department
College of Nurses of Ontario
101 Davenport Road
Toronto, Ontario
M5R 3P1
416-928-0900 ext 6295
1-800-387-5526
Fax 416-928-9643
www.cno.org
mbonathan@cnomail.org

From: June Porter [mailto:juneduesporter@cogeco.ca]
Sent: Monday, February 11, 2013 8:10 PM
To: Bonathan, Margo
Subject: just an item I would like clarified please

Hi Margo – just an item I would like clarified.

1. **Is this true regarding Physician assistants?** - Nurses (inclusive of RNs and RPNs) are not to action orders given by Physician Assistants. An order must come from the Physician as opposed to by means of a Physician Assistant.

Many thanks

June Duesbury-Porter