Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Humber River Hospital

And

Ontario Nurses’ Association

June 12, 2016
June 12, 2016

Ms. Susan Blair
Ontario Nurses Association
Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, Ontario, M5S 3A2

Ms. Marg Czaus
Chief Nursing Executive
Humber River Hospital
1235 Wilson Ave.
Toronto, ON, M3M 0B2

Dear Ms. Blair and Ms. Czaus,

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee that was constituted under Article 8.01 of the collective agreement between Humber River Hospital and the Ontario Nurses Association.

This report contains the Independent Assessment Committee’s findings and recommendations regarding the Professional Workload Complaint submitted by Nurses from the Hemodialysis Unit at Humber River Hospital.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all the parties regarding the complex issues and conditions that underlie a Professional Workload Complaint. The Committee has made 18 recommendations in five areas regarding issues that impact the workload of Registered Nurses.

The Members of the Independent Assessment Committee unanimously support all recommendations in this report. The Committee hopes that the recommendations will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues in the Hemodialysis Unit.
Sincerely,

Leslie Vincent RN MScA
Chairperson

Angela Preocanin RN
Nominee for the Association

Sylvia Rodgers RN
Nominee for the Hospital
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1. Introduction

1.1. Organization of the Independent Assessment Committee Report

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

1. Introduction

This section outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC’s jurisdiction as outlined in the Collective Agreement, and summarizes the Pre-Hearing, Hearing and Post-Hearing processes.

2. Presentation of the Professional Responsibility Workload Complaint

This section presents the context of practice relating to the professional workload complaint in the Hemodialysis Unit at Humber River Hospital; 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’), Humber River Hospital (‘the Hospital’) at the Hearing.

3. Discussion, Analysis and Recommendations

4. Summary and Conclusions

5. References and Appendices

The submissions and exhibits of the Ontario Nurses’ Association and Humber River Hospital are on file with both parties.

1.2. Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Hemodialysis Unit at Humber River Hospital. The Association stated the following in their pre-hearing submission:
“ONA submits this Professional Responsibility Complaint to be the result of the employer, assigning a high number of patients to individual RNs and groups of RNs. As per Article 8 of the Hospital Central Agreement RNs have submitted 180 PRWRFs to document when have been asked to perform more work than is consistent with patient care.”

1.3. **Jurisdiction of the Independent Assessment Committee**

The IAC is convened under the authority of Article 8.01 on Professional Responsibility in the Central Hospital Agreement between the Ontario Nurses’ Association and Humber River Hospital.

Article 8.01 states:

- **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) 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

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1 Submission to the Independent Assessment Committee by Ontario Nurses’ Association, 2016, p.6
2 Collective Agreement Between the Hospital and Ontario Nurses’ Association, Article 8 – Professional Responsibility, March 31, 2014, p.23.
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 IAC’s jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/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
examining 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 parties stressed to the board that the association and the participating hospitals all feel bound by the findings of such committees.”

The IAC’s jurisdiction ceases with submission of its written Report. The findings and recommendations of the IAC provide an independent external perspective to assist the Association and the Hospital to achieve mutually agreeable resolutions to workload issues. 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 of the Independent Assessment Committee were:

**Chairperson**
Leslie Vincent

**For the Association**
Angela Preocanin

**For the Hospital**
Sylvia Rodgers

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³ Arbitration Hearing Brantford General Hospital and Ontario Nurses Association, September 8, 1986.
1.4. Proceedings of the Independent Assessment Committee

Pre-Hearing

On April 30, 2014 the Association notified the Hospital and the IAC Chair in a letter that the Association was confirming an Independent Assessment Committee to investigate a complaint at Humber River Hospital and confirming the Chair as Leslie Vincent, the Association nominee, Angela Preocanin; and the Hospital Nominee, Treva McCumber. (Appendix 1).

The IAC members met by teleconference on May 21, 2014 and discussed the following issues:

- Overview of the IAC process and timeframes;
- Proposed dates for the IAC;
- Information requirements for the committee to assist in the IAC’s process and deliberations.

On May 28, 2014 the IAC proposed to the Hospital and the Association that the IAC be scheduled for November 24-26, 2014. The Association agreed to these dates, but the Hospital did not reply regarding their availability.

On June 12, 2014 the Hospital filed an Employer grievance, stating that the Association had violated the collective agreement articles 1, 6 and 8. (Appendix 2).

On July 28, 2014 the IAC chair again asked both parties for their availability to hold the IAC on November 24-26, 2014. The Association agreed; but no response was received from the Hospital. On September 12, 2014 the IAC chair requested that both parties submit their briefs to the IAC by October 31, 2014.

On September 12, the Hospital’s legal counsel sent a letter to the IAC chair requesting that the IAC be adjourned until the grievance filed on June 12, 2014 has been properly resolved through arbitration. (Appendix 3)

On September 25, the legal counsel for the Association sent a letter to the IAC chair asking that the IAC proceed on November 24, 2014. (Appendix 4)

On October 4, 2014, legal counsel for the Hospital sent a letter to the IAC chair stating their disagreement with the position by ONA that the IAC should proceed, and stating their view that the grievance be heard prior to the IAC. (Appendix 5)
On October 14, the IAC chair sent a letter to both parties stating that while the IAC panel was prepared to proceed on November 24, 2014, it was necessary for the Hospital and the Association to resolve their issues related to the grievance and the timing of the IAC. (Appendix 6)

On October 21, 2014 legal counsel for the Association sent a letter to the IAC chair stating that the Association was ready to proceed with the IAC in November. (Appendix 7)

On October 23, 2014 legal counsel for the Hospital sent a letter to the IAC chair requesting adjournment of the IAC until the grievance was held. (Appendix 8)

On November 4, 2014, the IAC chair sent a letter to both parties stating that an impasse had been reached between the parties regarding the timing of the IAC, and reluctantly cancelling the IAC until the grievance was heard in 2015. (Appendix 9)

On September 30, 2015, the IAC chair was notified by the Association that after two days of mediation, that the Hospital had withdrawn the grievance; and agreed to proceed with the IAC in February 2016.

On October 16, 2015, the IAC panel proposed the dates of March 2-4, 2016 for the IAC. Both parties agreed to these dates. On January 10, 2016 The IAC chair requested that both parties submit their briefs on February 8, 2016. On January 23, 2016 that IAC chair sent the agenda for the IAC (Appendix 10) and an information request for data from the Hospital (Appendix 11). The IAC also requested a tour of the Hemodialysis Unit on the first day of the IAC. The following ground rules for conduct during the IAC were provided:

1. Adhere to the agenda and the timeframes for presentation;
2. Opportunity will be given to ask questions for clarity at the end of each presentation. If either party has a question, please indicate this to the Chair;
3. Please speak from your own perspective and experience;
4. Do not raise issues related to individuals; the panel is not convened to address any concerns regarding individual performance;
5. The proceedings of the hearing are confidential and not to be discussed outside the hearing except for the purpose of preparing of the IAC meeting;
6. The briefs, presentations, discussion and any distributed documents in this hearing are not to be shared with other parties.
7. Maintain a professional demeanor at all times during the IAC meeting.
On February 22, 2016, the IAC met in preparation for the IAC meeting and to review the briefs submitted by both parties.

On February 25, 2015, the IAC chair was notified by the Hospital nominee, Treva McCumber, that she was unfortunately unable to be present at the IAC on March 2-4. Despite efforts by the Hospital to find an alternate nominee, the IAC was cancelled and rescheduled for March 29-31, 2016. The new nominee named by the Hospital was Sylvia Rodgers.

On March 28, 2016 the IAC chair was notified that the Hospital nominee was unable to attend the March 29-31, 2016 IAC due to family issues. The IAC was subsequently rescheduled for April 20-22, 2016.

The panel met in preparation for the IAC on April 20, 2016 prior to the tour of the Hemodialysis unit.

Prior to the hearing, both parties confirmed who would be in attendance at the hearing.

**Hearing**

**Wednesday, April 20 2016**

The IAC met at the Hospital at 1000 Hours on March 29, 2016 and were greeted by representatives of the Hospital and members of the Association. The IAC was provided with an extensive tour of the Hemodialysis unit. The tour served to familiarize the IAC with the work environment and physical layout of the unit.

The following individuals from the Hospital were on the tour:
- Melanie Tremblay, Director, Nephrology Program
- Dilshad Pirani, Manager, Nephrology
- Jennifer Duteau, Clinical Practice Leader

The following individuals from the Association were on the tour:
- Anne Gibb, RN Hemodialysis
- Elizabeth Astillero, RN Hemodialysis
- Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, ONA
Following a break, The IAC hearing convened at 1300 hour as per the agenda (Appendix 10). Participants and Observers on the respective hearing dates are listed in Appendix 12.

Following introduction of the IAC Committee members and representatives of the Association and the Hospital, the IAC Chair reviewed:

- The jurisdictional scope of the IAC, including the purpose of the IAC; and
- The ground rules for the Hearing procedure including confirmation that all participants understood and agreed.

Ms. Mariana Markovic, Professional Practice Specialist (PPS), presented on behalf of the Association. The Association’s presentation was based on their written Pre-hearing submission and supporting exhibits as well as a summary of the 187 Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses of the Hemodialysis Unit between 2011 and 2016.

Melanie Tremblay, Director of the Nephrology Program; Dilshad Pirani, Manager of the Nephrology Program; and Jennifer Duteau, Clinical Practice Leader presented on behalf of the Hospital. The Hospital’s presentation was based on their written pre-hearing submission and supporting exhibits.

**Thursday April 21, 2016**

The IAC Chair resumed the Hearing at 0900 hours. Melanie Tremblay, Dilshad Pirani and Jennifer Duteau provided the Hospital’s response to the Association’s submission. Members of the Hospital participated in the subsequent discussion. Ms. Markovic provided the Association’s response to the Hospital’s submission. Other members of the Association also participated in the subsequent discussion.

The IAC Chair adjourned the Hearing at approximately 1730 hours. Following adjournment of the Hearing, the IAC met during the evening to 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.
Friday, April 22, 2016

The IAC chair resumed the meeting at 0900 hr. Members of the IAC asked further questions in order to understand a range of issues in more detail and gaining further clarity of the issues arising from both parties’ presentations.

The IAC Chair concluded the hearing by thanking Ms. Angela Preocanin, Association Nominee and Ms. Sylvia Rodgers Hospital Nominee; as well as all the participants for their engagement and contributions in the Hearing process. The IAC Chair also communicated the hope that the parties will be able to move forward to seek resolution to the issues. The Chair also confirmed that IAC anticipated providing the final report within 45 days. The IAC Chair closed the Hearing at approximately 1300 hours.

Post Closure of Hearing

The IAC met in person on May 2, 2016. At this meeting, the IAC had extensive discussion and reviewed the draft report and analysis. Following the meeting, all IAC members contributed to the next version of the report and recommendations. The report was finalized on June 2, 2016.
2. Presentation of the Professional Responsibility Workload Complaint

2.1 Information on Humber River Hospital and the Hemodialysis Unit

The Hemodialysis Unit at Humber River Hospital (HRH) is located in Toronto, Ontario. Humber River Hospital is a regional acute care hospital and serves a catchment area of more than 850,000 people in the northwest Greater Toronto Area. In October 2015 the HRH moved into a new hospital at 1235 Wilson Ave. in Toronto. The hospital has approximately 650 beds, employs approximately 3400 employees including 1200 Registered Nurses (RNs) and 300 Registered Practical Nurses (RPNs).

The Hemodialysis In-Centre Unit is divided into the east and west wings with 61 dialysis stations. There is a central patient care station in each wing with views of all dialysis stations. The unit services 350 patients. There is an interprofessional team including RNs, RPNs, physicians, social workers, dieticians and pharmacists. The unit operates 7 days a week from 0700-2300, with 24-hour on call coverage for emergency treatments. On weekends, only half the unit is open.

Three types of services are provided:

- Conventional hemodialysis: 4 hour treatments, 3 times a week
- Short daily hemodialysis: patients receiving 2-3 hour treatments, 5-7 times per week
- Acute dialysis is performed in the ICU, Emergency, Cardiac Care and in-patient units

Most patients receive their treatment in the In-Centre with exception of those patients that are too ill to be moved to the centre from their unit of care.

2.2 History of Staffing in Hemodialysis Unit since 2011

2.2.1 Staffing in 2011

In 2011, the Hemodialysis Unit was located at the Church Street Site of Humber River Hospital. The unit had two wings with a total of 61 dialysis stations.

Staffing:

- Two Charge Nurses on days and two on evenings; the Charge Nurses have no patient assignment, but take one if necessary
• Table 1 displays the RN Staffing by Period of Day (not including Resource Nurse and Charge Nurse)

**Table 1: RN Staffing by Period Day**

<table>
<thead>
<tr>
<th>Shift</th>
<th>Number of RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700 – 1100</td>
<td>22</td>
</tr>
<tr>
<td>1100 – 1500</td>
<td>30 including 8 Float RN</td>
</tr>
<tr>
<td>1500 – 1900</td>
<td>26 including 8 Float RN</td>
</tr>
<tr>
<td>1900 – 2300</td>
<td>18</td>
</tr>
<tr>
<td>Acute off Unit</td>
<td></td>
</tr>
<tr>
<td>0700 – 1100</td>
<td>3</td>
</tr>
<tr>
<td>1100 – 1500</td>
<td>3</td>
</tr>
<tr>
<td>1500 – 1900</td>
<td>3</td>
</tr>
</tbody>
</table>

• RNs are assigned to a pod of 3 chairs and have 3 patient treatments going simultaneously
• Majority of treatments in 2011 were 3 to 4.5 hours long, 3 times a week. Short 2-hour treatments were increasing at the time.

2.2.2 **Staffing Changes from 2011-2013**

During the period of 2011 to 2013 numerous changes in nurse staffing and the model of care were implemented.

The changes included:
• Two (2) RNs from base staff were assigned to off unit patients;
• Removal of the Charge Nurse from 8 hour day and evening shift;
• Implementing the role of Resource Nurse in March 2012;
• Implementation of a new delivery care model and Registered Practical Nurses (RPNs) into the unit. The RPNs replaced six (6) RNs on the 8-hour day shift and evening shifts;
• Reducing the number of float RNs from 8 (eight) to 5 (five) on both the day and evening shifts;
• Implementation of a new master schedule. RPNs assigned to 8 hours shifts; RNs assigned to 8-hour shifts (Days, evenings) and 10-hour shifts (Tall Day (TD), Tall evening (TE));
• Setting the Nurse to patient ratio at: 3:1 conventional; 2:1 short daily; 2:1 segregation;
• Increasing the dialysis assistant hours;
• Addition of an additional clerical shift from 1500-2300;
• Conducting a review of non-RN duties was conducted and then assigning activities to other personnel;
• Bringing new hemodialysis machines into service:
• Hiring a new manager for the unit.
• Table 2 displays the RN Staffing by Period of Day

### Table 2: RN Staffing by Period Day

<table>
<thead>
<tr>
<th>Shift</th>
<th>Number of RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700 – 1100</td>
<td>22</td>
</tr>
<tr>
<td>1100 – 1500</td>
<td>25 including 3 Float RNs</td>
</tr>
<tr>
<td>1500 – 1900</td>
<td>21 including 3 Float RNs</td>
</tr>
<tr>
<td>1900 – 2300</td>
<td>18</td>
</tr>
<tr>
<td>Acute Off Unit</td>
<td></td>
</tr>
<tr>
<td>0700 – 1100</td>
<td>3</td>
</tr>
<tr>
<td>1100 – 1500</td>
<td>3</td>
</tr>
<tr>
<td>1500 – 1900</td>
<td>3</td>
</tr>
</tbody>
</table>

#### 2.2.3 Staffing Changes in 2013/2014

• The role of float nurses was eliminated.

#### 2.2.4 Staffing Changes in 2015/2016

• The RPN staffing was increased from six (6) to seven (7) on days and evenings; and RN staffing reduced.
• One Float RN was added on 8-hour days in April 2016 to provide break coverage to selected pods and to the Charge and Resource Nurses. The Hospital stated that this shift would be added on the weekend in the near future.
• A scheduling change in RNs was implemented in April 2016.
  - 9 (nine) TE shifts were reduced to 5 (five)
  - 7 (seven) 8hr-evenings were increased to 12
  - 3 (three) of the TE shifts are allocated to off-unit treatments.
2.2.5 Current Staffing

The RN and RPN staff are equally divided across both sides of the unit. Each nurse is assigned to a Pod of 3 stations. There is a Charge Nurse and a Resource Nurse on both day and evenings shifts. Two RNs are on call at night. A graphical depiction of the RN and RPN staffing by hour of day\(^4\) on Monday to Friday is included in Appendix 13 and Saturday-Sunday in Appendix 14.

The current staffing in the Hemodialysis unit for RNs Monday to Friday is:
- 0700 – 1500: 8 RN
- 0700 – 1700: 6 RN
- 1500 – 2300: 12 RN
- 1300 – 2300: 5 RN (2 in centre; and 3 off unit)
- 1 (one) RN on 8-hr day shift for break relief

The current staffing for RPNs Monday to Friday is:
- 0700 – 1500: 7 RPNs
- 1500 – 2300: 7 RPNs

On weekends, the staffing is reduced, as only one side of the unit is open.
The current staffing in the Hemodialysis unit for RNs on weekends is:
- 0700 – 1500: 3 RN
- 0700 – 1700: 4 RN
- 1500 – 2300: 7 RN
- 1300 – 2300: 2 RN (for off unit)
- 1 (one) 8-hr RN to be added on Day shift for break relief
- There is one Charge Nurse on days and evenings

The current staffing for RPNs on weekends is:
- 0700 – 1500: 4 RPNs
- 1500 – 2300: 4 RPNs

\(^4\) RN and RPN Staffing by Hour of Day on Monday to Friday; and Saturday/Sunday provided by Humber River Hospital at IAC on Friday, April 22, 2016.
Other staff includes:
• Clerical Staff: staggered shifts with coverage from 0600-2330.
• Dialysis Technologists
• Dialysis Assistants
• 1530-2330: 1 DA
• Housekeeping

Additional, the following staff work Monday to Friday:
• Body Access Coordinator
• Independent Dialysis Coordinator
• Clinical Practice Leaders
• Clinical Instructor
• Patient Care Manager
• Patient Service Coordinator provides additional support after hours

2.3 Workload Concerns of Registered Nurses and Discussions at the Hospital Association Committee

There were 187 Professional Responsibility Workload Responsibility Forms (PRWRFs) submitted between 2011 and 2016.
• 2011: 21 PRWRFs
• 2012: 75 PRWRFs
• 2013: 61 PRWRFs
• 2014: 19 PRWRFs
• 2015: 4 PRWRFs
• 2016: 7 PRWRFs

During the presentation the Association stated that the nursing workload problems are as a result of following issues:
• Professional Practice including practice standards, nurse leadership
• Patient acuity
• RN and RPN practice
• Fluctuating workload
• Fragmented and interrupted care
• Fluctuating staffing and RN staffing
• Excellent Care for All Act, 2010.
The Association provided 37 recommendations\(^5\) in their brief submission for resolution of the workload. The recommendations can be summarized under RN and RPN staffing, patient assignments, leadership and leadership accountability and responsibility, governance structure engaging front line staff; timely and effective processes to resolve workload concern, education support; a fatigue management program, documentation and model of care.

- **RN and RPN staffing:**
  - Base staffing accounts for time/resources for consultation; patient assessment; patient care needs; receiving report; documentation; replacement for orientation and professional development
  - RN/RPN staffing mix
  - RPN role clarity
  - RNs replaced with RNs
  - Increase staffing of 4 RNs/day assigned to role of Float Nurse on 11.25 hr. tours
  - Adjust staffing to 80/20 RN to RPN ratio; Replace 4 RPNs out of 7 working regular 8 hour tours on Days and Evenings
  - Utilize best practice guidelines/standards with regard to staffing and workload

- **Patient assignments:**
  - Use of evidence based tools and the Three Factor framework in making decisions regarding RPN staffing; and subsequently for patient assignments
  - Appropriate assignment of patients to RNs and RPNs; engagement of nursing staff in assignment decisions
  - Patient assignment tool and policy to be developed and evaluated

- **Leadership and leadership accountability and responsibility;**
- **Governance structure engaging front line staff; engagement in planning, development of healthy work environment;**
- **Timely and effective processes to resolve concerns related to professional practice, acuity, workloads and staffing;**
- **Education support and dedicated educator;**
- **Comprehensive fatigue prevention and management program;**
- **Standardized documentation and handover (transfer of care) at end of patient runs and shift change; and**

\(^5\) Submission to the Independent Assessment Committee by Ontario Nurses’ Association, p. 46-49.
• Model of care to reduce fragmentation of care.

The Association stated that the increasing patient workload requires Registered Nurses (RNs) to perform more work than is consistent with proper patient care. During and following the presentation, the Association responded to questions of clarification from both the Hospital and IAC.

Melanie Tremblay, Director of the Nephrology Program; Dilshad Pirani, Manager of the Nephrology Program; and Jennifer Duteau, Clinical Practice Leader presented on behalf of the Hospital. The content of the Hospital’s presentation was based on their written pre-hearing submission. The presentation provided the Hospital’s view on:
• Hospital accountabilities to the Ontario Renal Network;
• Program leadership;
• Transition from Church site to Wilson site;
• Model of Care;
• Orientation of staff and competencies of staff;
• Patient scheduling and assignment to nurses within the Hemodialysis Unit;
• Nursing workload throughout shifts; at changeover.

The Hospital recommendations included:
• Additional RN staff for break/relief support; hours and shifts based on unit activity;
• Scheduling to optimize staff utilization and assess workload;
• Complete environmental scan regarding staffing and patient population;
• Refining Patient Needs Assessment Tool to identify RN only assignments;
• A regular review process to assess and document patients for stability/predictability to support patient assignments to appropriate staff with appropriate workload;
• Processes for staff to update the Resource Nurse on significant changes/events during dialysis;
• Establish and monitor statistics to reflect significant event including transfer of care from RN to RPN; admission of patients post-dialysis; number of patients requiring post-dialysis observations; number of daily treatments, off unit treatments, urgent unplanned off unit treatments, cardiac arrests, circumstances when staffing not adequate, replacing RNs with RPNs due to unavailability;
• Meeting regularly with staff to address their concerns;
• Establishing a practice committee;
• Consultation with RPNAO re RPN role;
• Working with union partners re timely addressing of workload complaints as per Article 8.01.
2.4 Meetings between Association and Hospital Prior to IAC

There were several meetings between the Association and the Hospital in an effort to resolve the issues arising from the PRWRFs. Initially the PRWRFs related to the Hemodialysis unit were discussed in the Hospital Association Committee (HAC).

On February 3, 2012, Ms. Mariana Markovic notified the Hospital that the Association’s intent to bring forth the issue of professional responsibility related to the ongoing problems identified in the PRWRFs, and if not resolved, to refer the issues to an Independent Assessment Committee.

A Professional Responsibility Committee met on February 28, 2012; April 3, 2012; June 26, 2012; November 7, 2012. Fourteen issues were identified and discussed during these meetings including staffing, vacancies, overtime, equipment, roles and responsibilities of various team members, assignments, off unit treatments, patient volume and acuity. Information was provided by the Hospital to the Association on role descriptions, staffing, sick time, model of care, patient treatments, education sessions and staff meetings.

Following the November 7 meeting, the Hospital provided a Letter of Understanding to the Association that detailed a list of improvements to address most of the professional responsibility concerns. Improvements identified by the Hospital were:

- New care delivery model implemented in October 2012 to resolve RNs being pulled off unit during changeover to do off unit treatments.
- Patient assignments changed to put all conventional treatments at main pods; and short (2 hr.) treatments in expansion C100. This change was to resolve an RN picking up a 2nd 2-hour patient.
- A new master schedule as implemented with a float nurse assigned per pod during changeover.
- The ratio of staff was to be 3:1 for conventional treatments; 2:1 for short daily treatments; and 2:1 for patients requiring segregation.
- An additional dialysis assistant shift was implemented from 1000-1800 in order to provide additional support at changeover and for off-unit treatments.
- Role of Resource Nurse implemented with no patient assignment.
- Additional clerical associate shift implemented between 1500-2300.
- Patient treatment spots assigned by the Resource Nurses to balance workload assignments of RNs.
- New description for float nurses implemented with no patient assignment.
- Non-nursing duties assigned to clerical staff, housekeeping, and dialysis assistants.
The Letter of Understanding was not executed.

It was agreed to establish a Hemodialysis Unit Task Force and terms of reference were developed in June 2012. The purpose of the task force was to develop, implement and evaluate effective strategies to address workload concerns noted under the professional responsibility concerns submitted since September 2011. The stated measure of success of the task force was to identify strategies within the allocated resources to ensure the achievement of positive patient outcomes. According to the minutes provided in the Hospital brief, the Task Force met on four occasions between December 2012 and February 2013. On April 3, 2013, the Association advised the Hospital that the union would not be continuing the task force because RPNs were being introduced into the unit.

On June 18, 2013, the Association advanced the Professional Responsibility Complaint to the Ontario Hospital Association to identify the next available IAC chair.

The Hospital filed an employer grievance on June 12, 2014. Following the grievance filed by the Hospital, both parties participated in two days of mediation on January 26, 2015 and September 29, 2015. The Hospital withdrew the grievance on September 29, 2015; and both parties agreed to meet on November 2 and 3, and December 18, 2015; and subsequently on February 2, 2016. The issues discussed during these meetings were:

- November 2-3, 2015: Professional practice, patient acuity, fluctuating workload and fluctuating staffing;
- December 18, 2015: RN/RPN assignment, model of care, roles of RN and RPN on interprofessional team, communication, breaks and education for RPN;
- February 2, 2016: review of process for assignments; break assignments and acuity tool follow-up.

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6 Terms of Reference – Hemodialysis Task Force, Submissions on Behalf of the Humber River Hospital, Tab 9.

7 Dialysis Task Force Meeting Agendas and Meeting, Submissions on Behalf of the Humber River Hospital, Tabs 11-14.
3 Discussion, Analysis and Recommendations

Five issues that impact on nursing workload in the Hemodialysis unit were identified by the IAC. The issues are:

1. Registered Nurse Staffing and Scheduling
   a. Determining the Assignment of RN or RPN to Patients to ensure adequate and safe RN Staffing
   b. Supporting Consultation and Collaboration among Nursing Staff
   c. Nurse Scheduling

2. Patient Volumes, Types of Treatment and Scheduling

3. Documentation

4. Communication and Decision Making


3.1 Registered Nurse Staffing and Scheduling To Ensure Adequate and Safe RN Staffing

Nurse staffing is recognized as a structural measure of quality and adequacy of staffing levels is linked to patient safety and quality of care. Ongoing evaluation of nurse staffing and outcomes related to patient safety and quality are essential.

Since 2011 there has been steady erosion of Registered Nurse (RN) staff complement in the Hemodialysis unit, primarily due to layoffs, attrition and replacement of full time positions with part time positions. During the same period of time there have been frequent changes in RN scheduling with regard to the number of RNs per shift and the duration of shifts. In addition there have been many changes, including layoffs, which have altered the number of full and part time RNs working in the hemodialysis unit.

The hospital provided comparative data on RN budgeted FTEs and headcount from 2013-2016, which is reproduced in Table 3. Total RN FTEs decreased by 14.05 FTEs from 73.43 in 2013 to 59.38 in 2016. During the same period, the RPN staff budget increased to 7.82 FTEs. This resulted in a net decrease in 6.23 FTEs in RN staffing (14.05 less 7.82), while patient volumes have remained the same in the prevalent chronic dialysis patients and increased in the acute off unit patient population.

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8 Data on RN and RPN Budgeted FTEs 2013 – 2016, Humber River Hospital, Submitted to IAC on Friday, April 22, 2016.
Table 3: Budgeted RN and RPN Staffing and Headcount from 2013 – 2016.

<table>
<thead>
<tr>
<th>Type of Staff</th>
<th>2013-2014</th>
<th></th>
<th>2014-2015</th>
<th></th>
<th>2015-2016</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FTE</td>
<td>Headcount</td>
<td>FTE</td>
<td>Headcount</td>
<td>FTE</td>
<td>Headcount</td>
</tr>
<tr>
<td>RN Full time</td>
<td>60</td>
<td>60</td>
<td>46</td>
<td>46</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>RN Part time</td>
<td>13.42</td>
<td>22</td>
<td>13.67</td>
<td>25</td>
<td>15.38</td>
<td>23</td>
</tr>
<tr>
<td>Casual RN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Total RN</td>
<td>73.43</td>
<td>80</td>
<td>59.67</td>
<td>71</td>
<td>59.38</td>
<td>77</td>
</tr>
<tr>
<td>RPN Full time</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>RPN Part time</td>
<td>3.85</td>
<td>6</td>
<td>3.82</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RPN</td>
<td></td>
<td>10</td>
<td>7.82</td>
<td>21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Determining Assignment of RN or RPN to Patients to Ensure Adequate and Safe RN Staffing:

In 2012-2013 the Hospital consulted other hospitals where RPNs were employed in hemodialysis units. During this consultation the Hospital examined the scope of the RPN role in hemodialysis, qualifications, orientation processes, as well as the ratios of RNs to RPNs. A decision was made by the Hospital to go to a 70/30 RN:RPN staffing model in the Hemodialysis Unit.

The Hospital created a Collaborative Model of Practice for Hemodialysis: Registered Nurse and Registered Practical Nurse in Partnership\(^9\) and a Dialysis Unit Acuity Monitoring Tool\(^8\), to determine which patients should be assigned to an RN or RPN based on complexity, predictability and risk of negative outcomes. During later discussions with the Ontario Nurses’ Association, ONA recommended

\(^9\) Submissions on Behalf of the Hospital, Tab 38.
the use of another acuity monitoring tool developed by Grand River Hospital. The Hospital provided data on the concurrent application of both tools on the prevalent dialysis patient population in the Humber River Dialysis unit. This application was conducted by the Clinical Practice Leader and the Resource Nurse in November 2015 and again in February 2016 on the prevalent dialysis patient population. Table 4 provides the results of this application and the number/percentage of patients that theoretically could be assigned to an RPN, or should be assigned to an RN.

Table 4: Assignment of Patients to RN or RPN based on the Application of Dialysis Unit Acuity Monitoring Tool

<table>
<thead>
<tr>
<th>Date of application of monitoring tool</th>
<th>Total Number of Patients Assessed</th>
<th>Tool Utilized</th>
<th>Total number and Percentage that Should be Assigned to an RN</th>
<th>Total number of Patients that could be Assigned to an RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 18, 2015</td>
<td>318</td>
<td>HRH</td>
<td>14 (4.4%)</td>
<td>304 (95.5%)</td>
</tr>
<tr>
<td>February 2016</td>
<td>287</td>
<td>HRH</td>
<td>76 (26%)</td>
<td>211 (73%)</td>
</tr>
<tr>
<td></td>
<td>287</td>
<td>Grand River</td>
<td>170 (59%)</td>
<td>125 (43%)</td>
</tr>
</tbody>
</table>

The two tools provided widely varying estimates of the number of patients to be assigned to either category of nurses. Neither of the acuity monitoring tools has undergone a formal, rigorous evaluation for reliability and validity.

The HRH acuity monitoring tool has only been utilized intermittently as a means to determine the proportion of patients that could theoretically be assigned to an RPN or should be assigned to an RN. On a daily basis, the Resource Nurse determines the assignment based on clinical judgement and utilizing the acuity monitoring tool as a resource. Patient records and the shift transfer report are used as other data sources to make the assignments. The Resource Nurse also utilizes the Community Wide Patient Scheduling Tool (CWPST) which is completed by the clerical staff. The CWPST is the tool where patients

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10 Submissions on Behalf of the Hospital, Tab 28 and 29.
are assigned to station and time for their treatment. Once the Resource Nurse has determined the nurse assignments, this information is added to the CWPST.

Recently new pre and post assessment screens were added to the patient record. The elements of the Post assessment screen contains selected indicators from the HRH acuity monitoring tool. The results of the post assessment screen are automatically added to the Community Wide Patient Scheduling Tool for each patient, in an effort to assist the Resource Nurse in making appropriate assignments.

It is unknown if these are the best indicators to utilize or if more or different indicators should be added to be reflective of patient condition/reactions to treatment. For example, should the indicator for critical results be more sensitive to any critical result in the last 3 months? Is this the most suitable time frame for evaluation? Does the Resource Nurse have ready access to all the pertinent information on almost 300 hemodialysis patients and their current status to make the best judgement on nurse—patient assignments on a daily basis?

There did not appear to be regular and systematic monitoring/evaluation of nurse staffing and the adequacy of RN staffing. The infrequent use of a non-validated acuity tool is insufficient. While the Hospital reports data to the Ontario Renal Network for the ongoing monitoring of hemodialysis programs, the indicators are related to patient volumes, type of care, timeliness and location of care. Recent benchmarking study\(^\text{11}\) conducted by the Hospital in 2016 included some staffing indicators (e.g. number of nurses on each shift, proportion of RNs/RPNs) but did not include what methods/tools other hemodialysis units utilize to determine nurse staffing.

**Supporting Consultation and Collaboration among Nursing Staff**

The College of Nurses of Ontario Practice Guideline on RN and RPN Practice: the Client, the Nurse and the Environment\(^\text{12}\) utilizes three factors (the client, the environment and the nurse) to guide decision making on care-provider assignments and the need for consultation and collaboration. The HRH Collaborative Model for Practice for Hemodialysis states that RNs and RPNs will consult and collaborate as necessary for patient care.

The RPNs consult RNs on a regular basis although there has been no evaluation of the degree/frequency of consultation/collaboration with the exception of the monitoring of Transfer of Accountability.

\(^\text{11}\) Submissions on Behalf of the Hospital, Tab 37

\(^\text{12}\) College of Nurses of Ontario. *RN and RPN Practice: the Client, the Nurse and the Environment*, 2014
However, TOA only occurs when the consultation/collaboration process is insufficient to meet patient needs, and therefore is not a good measure of the time and workload involved with ongoing consultation and collaboration among RNs and RPNs.

Effective and timely consultation and collaboration between RNs and RPNs is essential to provide safe and quality patient care. Arguably, the patients in the HRH hemodialysis unit that are assigned to RNs are more complex than those assigned to RPNs, as the RNs must be assigned to those patients who are less stable, less predictable and at higher risk of negative outcomes. In addition, RNs are assigned to all off unit patients. The RNs view the RPNs as their colleagues and understand their professional accountability and responsibility to support the RPNS through consultation, collaboration and/or transfer of accountability.

However, the time involved in consulting and collaboration with RPNs is additional work for the RNs. This was described by the RNs as challenging given the current availability of RNs in the unit especially during breaks and times of patient turnover. Additionally, the RN must continue the care of her own patients, while consulting with the RPN, possibly resulting in interruptions and/or delays in care.

**Nurse Scheduling:**

Currently the RNs work a combination of 8-hour and 10-hours shifts; with start times of 0700, 1300 or 1500. As a result of the length and start time of RN shifts, the RN staffing has peaks and valleys during a typical 18-hour workday, ranging from 14-23 RNs at any one time during weekdays. The time of greatest overlap of RN shifts is 1300-1700. During the periods of lower RN staffing there is a lack of adequate RN coverage or shift breaks and patient turnover. There is frequent demand for the Charge and Resource Nurses to provide patient care (break coverage for nurses, patients requiring observation etc.), diverting them away from their leadership roles. Recently a new shift from 0700-1500 was added during the week because of the need to provide break coverage for the Charge Nurse and Resource Nurse, break coverage for the pods with private rooms, and for patients requiring observation after treatment. The geography of unit is such that some pods are not visible from the nursing stations, making break coverage challenging.

Over the last 5 years, there appears to have been little engagement of and/or discussion with the nursing staff regarding any of the decisions regarding nurse staffing/scheduling before or after implementation. Nor was it evident that there was any systematic evaluation by management of the many staffing and scheduling changes.
3.2 Patient Volumes, Types of Treatment and Scheduling

The In-Centre Hemodialysis Unit currently provides care to 357 chronic dialysis patients. This volume of patients is unvaried over the last years. The unit also provides acute off unit treatments to admitted patients. The Hospital provided a comparison of patient volumes between 2014-2015 and 2015-2016 (Q3). This data is displayed in Table 5.

**Table 5: Patient Volumes 2014-2016.**

<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>2014-2015</th>
<th>2015-2016 (as of Q3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3 (1:1 off unit patients)</td>
<td>1,558</td>
<td>2,057</td>
</tr>
<tr>
<td>In Facility (3 to 4 hour treatments)</td>
<td>40,777</td>
<td>41,215</td>
</tr>
<tr>
<td>In Facility (2 hour treatments)</td>
<td>17,652</td>
<td>17,410</td>
</tr>
</tbody>
</table>

While the in facility patient volumes are relatively unchanged, there has been a sharp increase in the number of Level 3 off unit patients since the transition of the Hospital to the Wilson Site (from 1,158 in 14/15 to 2,057 in 15/16). The Hospital believes that this is due to the increase in ICU beds (from 27 to 40) since the transition, resulting in an increased demand for acute dialysis in this patient population. The Hospital also noted that the number of patients transferred by the Hospital through Criticall has significantly decreased since the additional ICU beds have opened. The considerable increase in Level 3 off unit patients is having a significant impact on RN workload as only RNs are assigned to these patients due to their complexity, instability and risk for negative outcomes.

The Hemodialysis program at Humber River Hospital has a significantly larger number of patients on 2-hour treatments (versus 3 or 4 hour treatments) in comparison to other similar units. This results in a higher turnover of patients every day. Patient turnover is associated with a considerable amount of workload that is not accounted for in the current staffing levels.

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13 Ontario Renal Network, Prevalent Chronic Dialysis Patients, Humber River Hospital Q3 FY15/16 Program Scorecard

Patients are scheduled for treatment during one of 3 shifts in the morning, afternoon or evening. Each treatment pod has 3 chair/beds and start times are 15 min apart. Keeping to the schedule for start times is not always achievable due to many factors including patient factors (delay in arrival to the unit, access issues) and/or dialysis machine issues. As a result nursing staff are frequently getting behind just as they start the shift because delays are common and probably unavoidable. There is not a specific standard for start times spacing in dialysis units, and apparently varies from 15-30 min depending on the hospital. The RNs noted that it is very challenging to adequately assess each patient, initiate treatment and document care during this 45 minute time frame. Documentation is frequently deferred to later in the shift.

3.3 Documentation

Humber River Hospital currently uses Meditech for the electronic health record for clients. Nurses do the majority of their documentation in Meditech. The paper based patient flow sheet (utilized to record readings and other information during treatment from the dialysis machines) was discontinued after the move to Wilson site as the new unit has Integrated Bedside Terminals (IBTs) and a computer station within each pod. It was planned that nurses could enter data utilizing the IBTS and the computer stations. However, the IBTs are the entertainment/communication device for patients, so in practical terms are not available to the nursing staff. The dialysis machines not interfaced with Meditech. As a result, nurses were observed by the IAC members while on a tour of the unit to be recording information/data on a variety of informal flow sheets as a means to retain data for documentation in the electronic health record. This documentation “workaround” seems unavoidable at this time given that the Dialysis machines are not interfaced with Meditech.

In addition, the tight start times and rapid patient turnover result in little or no time for timely and appropriate documentation during the first hours of care.

3.4 Communication and Decision Making

The engagement of nursing staff in a meaningful way regarding their work and work conditions is essential in creating an effective work environment to support high quality patient care.

Communication with staff is both formal and informal in the Hemodialysis Unit. Email is relied upon extensively to communicate information to nurses including decisions regarding staffing. Some changes appear to be implemented at times with no formal communication (e.g. schedule changes). The Clinical
Practice Leader sends a weekly email to all staff with clinical and safety updates, education opportunities and other information she feels the staff may require. There were no information boards for staff in the unit. Performance data (e.g. ORN report cards) are shared with staff intermittently but this seemed to be primarily verbal. The staff meetings are intermittent and short in duration; and minutes are not consistently done.

Important decisions on staffing and scheduling appear to be made by leadership with little or no consultation and/or discussion with nursing staff. The Hemodialysis Task Force was not sustained due to the Association’s withdrawal from the meetings. While there was considerable engagement of staff to support the transition to a new hospital, issues of staffing and workload were not discussed as part of the transition planning.

3.5 Process for Management of Professional Responsibility Workload Report Form (PRWRFs)
During the period of 2011 to 2016 there were 187 professional responsibility workload report forms submitted by RNs to the Hospital. During this time there was a haphazard process for timely review of forms and communication back to staff. The process for addressing PRWRFs, as outlined in the collective agreement was not consistently followed. Efforts related to the Hemodialysis Task Force, established to work on workload issues, were not sustained. In the fall of 2015 and winter 2016, the parties did meet on three occasions, but were not successful in reaching an agreement on the workload issues.

3.6 Recommendations:
The Independent Assessment Committee makes the following recommendations regarding workload issues in the Hemodialysis Unit at Humber River Hospital.

Related to RN/RPN Assignments:
1. Conduct a formal evaluation of the acuity monitoring tools for reliability and validity. The evaluation should minimally include the acuity tool designed by Humber River Hospital and the tool designed by Grand River Hospital.
2. Develop a set of indicators for regular evaluation of RN staffing; and which can also be compared with other hemodialysis units. This may include RN/RPN hours of care per day, and ratio of hours to patient treatments.
3. Evaluate the post assessment screen to determine the utility of the current indicators in determining RN or RPN assignment; and revise as necessary.
4. In addition to the prospective use of the acuity monitoring tool in assigning patients to RNs and RPNs, conduct a regular retrospective “real time” audit of whether the assignments were
appropriate. This would provide some measure of evaluation of the acuity tool and the ability of the Resource Nurses to make appropriate assignments based on the information available to them.

5. Develop a method for quantifying the number and type of consultations and collaboration efforts made on a daily basis between RNs and RPNs. The identification of why RPNs consult RNs would inform both appropriateness of patient assignments and opportunities for improvement in care.

Related to Nurse Staffing:

6. Maintain the newly implemented 8-hr Float RN shift on days for break coverage of isolation rooms, Charge Nurse and Resource Nurse.

7. Increase RN staffing on a daily basis by increasing the number of RNs in a float nurse role. This staffing increase will:
   a. Ensure RN time and availability to engage in effective consultation and collaboration with RPNs;
   b. Ensure that the RPNs have ready access to an RN during breaks;
   c. Provide adequate break coverage;
   d. Align staffing with patient volume, care demands and turnover;
   e. Allow for unplanned events/delays (e.g. patients requiring observation; access issues; late arrival of patients from inpatient floors);
   f. Support timely documentation of care;
   g. Free up the Charge Nurse and Resource Nurse from break coverage;
   h. Sick call coverage.

This could be accomplished by starting two TE evening shifts earlier than the current start time and by adding 2.8 FTEs in additional RN hours, deployed to the role of Float Nurses.

   a. Add Two float RNs; assigning one to each side of the unit; starting at 1100 (Monday to Friday)
   b. Add 2 Float RNs on Saturday and Sunday with staggered start times. (e.g. one at 11, and one later).
   c. Start two (2) of the TE RNs at an earlier time (e.g. 1200)

8. Review the Full time and Part time complement of RNs to ensure adequate number of RNs available to work in the unit.

Related to Patient Volumes and Scheduling:
9. Closely monitor volume and type of patient and staff accordingly (off unit, 2 hour treatments).
   Increase the RN staffing to support the increased volume in acute off unit that has been experienced post transition to Wilson site
10. Stagger start times 30 min apart to allow nurses adequate time for assessment, initiation of treatment and documentation.

**Related to Documentation:**

11. Ensure there is adequate time in the shift to support timely and accurate documentation of patient care in the record.
12. Develop an interface between the dialysis machines and the Meditech health record.
13. Implement a flow sheet for nurses until interface is achieved.

**Recommendations for Communication and Decision Making:**

14. Create a regular staff forum where issues related to staffing, scheduling and other operational issues in the unit can be discussed with leadership.
15. Create a Quality Board or other area for posting of performance data on hemodialysis including patient volumes.
16. Ensure that staff are notified of upcoming staff meetings, with an opportunity to contribute to the agenda; agendas and minutes should be readily available.
17. Establish regular staff huddles during each shift to support timely discussions of patient flow, safety concerns, other issues of concern etc.

**Recommendations re Process for Management of PRWRFs:**

18. Form a Sub-HAC committee for hemodialysis unit to discuss monthly if there are workload complaints to review.

**4. Conclusion**

This report contains the Independent Assessment Committee’s findings and recommendations regarding Professional Workload Complaint submitted by Nurses from the Hemodialysis Unit at Humber River Hospital.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all the parties regarding the complex issues and conditions that
underlie a Professional Workload Complaint. The Committee has made 18 recommendations in five areas regarding issues that impact the workload of Registered Nurses.

The Members of the Independent Assessment Committee unanimously support all recommendations in this report. The Committee hopes that the recommendations will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues in the Hemodialysis Unit.
Appendix 1: Letter from the Association April 30, 2014.

Ontario Nurses’ Association
85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2
TEL: (416) 964-8833 FAX: (416) 964-8864

April 30, 2014

Leslie Vincent
716 Windermere Ave.
Toronto, ON, M6S 3M1

Dear Ms. Vincent,

Re: Humber River Hospital – Hemodialysis Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association, File No. 201202042

Thank you for accepting the request to chair the next IAC investigation and hearing.

In accordance with Article 8.01 of the Central Hospital Agreement set out between Ontario Nurses’ Association (ONA) and Humber River Hospital (HRH), the Labour Management Committee (HAC) has met on a number of occasions and exchanged letters of communication several times in attempts to bring resolution to workload issues causing RNs working in the Hemodialysis Unit to believe that they are being asked to perform more work than is consistent with proper patient care.

Ontario Nurses’ Association considers the unresolved workload issues to constitute Professional Responsibility concerns, as applied to regulated health professionals by the College of Nurses of Ontario (CNO) under the Regulated Health Professions Act (RHPA). The Association views the professional responsibility concerns of RNs to be a result of being assigned more work by the Employer than what is consistent with proper patient care.

The RNs working in the Hemodialysis Unit at the HRH have identified workload issues and the work environment to make it difficult to provide safe quality patient care and to practice safely in accordance with the professional standards set out by the CNO for RNs. The effect of the workload and the working environment on RNs relates to professional practice, patient acuity, fluctuating workloads, and fluctuating staffing.

Attempts at working towards resolution of workload issues that constitute professional practice concerns at HAC meetings with the Employer have been unproductive. The Employer is resolved to move forward to an IAC hearing to address the professional practice responsibility concerns that have been presented to them. The Association has no other recourse at this time but to forward this matter to a hearing before the Independent Assessment Committee. To this effect ONA respectfully submits this Professional Responsibility Complaint to the IAC.
ONA’s Nominee is Angela Preocanin, RN, and her contact information is:

Angela Preocanin, RN
3257 Woodward Ave.
Burlington L7N 2M7
Tel: 905-512-7413
Email: apreocanin@cogeco.ca

We are informed that the Employer’s Nominee is Treva McCumber, RN, DHSc, and her contact information is:

Treva McCumber, RN, DHSc
Vice President, Transitions, Diagnostics & CNO
Royal Victoria Regional Health Centre
201 Georgian Drive
Barrie, ON L4M 6M2
Tel: 705-728-9090 Ext. 46000
Fax: 705-728-2408
Email: mccumbert@rvh.on.ca

Once you have the information you require, it is our understanding that as the IAC Chair you will communicate with the two Nominees to set up a date for the hearing that is agreeable to both parties, the Employer and ONA.

We thank you for your assistance in this matter.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic

Mariana Markovic
Professional Practice Specialist
Labour Relations Officer

C:
Catherine Green, HRH, Manager Labour Relations
Melanie Tremblay, HRH, Renal Program Director
Scott Jarrett, HRH, Vice President of Patient Relations
Reuben Devlin, HRH, President & CEO
Mary Veneziano, Executive Administrative Assistant to the President & CEO and Board of Directors, on behalf of Paul Allison, HRH, Board of Directors Chair
Michael Howell, ONA, Local Coordinator and BUP
Sheri Street, ONA, Servicing LRO
Doug Anderson, ONA, Manager Provincial Services Team
Beverly Mathers, ONA, Manager South District Service Team
Valerie McDonald, ONA, Manager Labour Relations
David McCoy, OHA, Manager Labour Relations
Angela Preocanin, RN, ONA Nominee
Hi Leslie

Please find attached an Employer Grievance which we sent to ONA on Friday concerning the Hemo IAC.

If you have any questions, please do not hesitate to contact me.

Thanks

Catherine Green RN
Manager, Labour Relations
Tel. 416-747-3780
Fax. 416-747-3758
e-mail: cgreen@hrh.ca

"Please note Humber River Hospital has moved to a new email address extension, @hrh.ca  Please update your contact information. Thank You."

Grievance

Dated June 12, 2014

We the Humber River Hospital grieve that the Ontario Nurses Association has violated the Collective Agreement Articles 1.5.8 and any other relevant provisions by improperly advancing workload and other issues arising in the Hospital’s Hemodialysis Unit to an Independent Assessment Committee, with such violations including:

Failure to follow the process as detailed in the Collective Agreement
Failure to ensure that the issues advanced address legitimate patient care concerns arising from assigned workload
Failure to adhere to required timelines in raising workload issues
And arbitrarily withdrawing union participation in a mutually established problem solving process for the Hemodialysis unit

such that the entire IAC process amounts to an abuse of the Professional Responsibility intent and process in the collective agreement.

Redress

1. An order that the Association cease and desist from violating the Collective Agreement
2. An order that the violations precludes the Independent Assessment Committee for Hemodialysis Unit from having jurisdiction to consider some or all of the issues referred to it.
3. An order that in the future before any workload issues may be considered by any Independent Assessment Committee requested by the Association at Humber River Hospital, such issues must be supported by demonstrable evidence of staff being asked to perform more work that is consistent with proper patient care or actual risks to patient safety directly related to the issue being raised instead of empirical studies and academic articles unrelated to the actual working conditions of the Unit at issue.
4. An order that the steps outlined in section 8.01 of the collective agreement must be followed for professional responsibility workload reports.
5. An Order that the Association conduct mandatory in - services regarding the purpose and process of

39
Article 8 of the collective agreement for its members at Humber River.

6. That the Association post a declaration on all Association bulletin boards that they have violated the Collective Agreement.

7. That the Association reimburse the Hospital all monies that been spent in preparation of the Hemodialysis Independent Association Committee.

8. And any other remedy to make the Hospital whole in all respects and circumstances.

9. And any other remedy deemed appropriate by an Arbitrator.

Signature: 

Date: June 12, 2014

www.h mh.ca Patient Care Reinvented.

UNIVERSITY OF TORONTO
Appendix 3: Letter from Hospital’s Legal Counsel September 12, 2014.

File No. 631-490
September 12, 2014

VIA EMAIL

Leslie Vincent
Chair, IAC Panel
716 Windermere Ave.
Toronto, ON, M6S 3M1

Dear Ms. Vincent:

Re: Humber River Hospital and ONA Dialysis IAC
Preliminary Issues

We are counsel to the Hospital in respect of the Independent Assessment Committee hearing for the Dialysis unit. In that regard we have seen your email of today to the parties regarding written submissions.

As you may be aware, the Hospital filed a grievance against ONA regarding this IAC referral.

The grievance has now been heard through the grievance procedure outlined in the parties’ collective agreement. As the dispute was not settled, the process of selecting an arbitrator to determine the grievance is beginning.

While there are a number of components to the grievance, the primary issue at this stage is the Hospital’s challenge to the jurisdiction of this IAC panel to preside over the hearing given the manner in which the various workload complaints were referred by ONA.

As you are no doubt aware, the Independent Assessment Committee is a process defined by the collective agreement between the Hospital and ONA. As a result, the manner in which ONA workload concerns are to be raised and addressed is entirely defined by the provisions of the Article 8 of the collective agreement.

Where ONA or its members fail to adhere to the process set out in the collective agreement for advancing workload concerns, it is the Hospital’s position that any subsequent IAC panel is not properly constituted.
This is the basis of the Hospital's grievance in respect of this IAC hearing.

Accordingly, we are requesting your confirmation that the IAC hearing will be adjourned until the grievance has been properly resolved through arbitration so that the issues surrounding this panel's jurisdiction to hear the workload complaints can be addressed.

Please feel free to contact me directly if you have any questions.

Yours very truly,

[Signature]

Jason Green
Appendix 4: Letter from Legal Counsel for Association September 25, 2014.

CAVALLUZZO

September 25, 2014

BY E-MAIL: ieslvincent@sympatico.ca

Leslie Vincent
Chair, IAC Panel
716 Windermere Ave.
Toronto ON M6S 3M1

Dear Ms Vincent:

Re: Ontario Nurses’ Association and Humber River Hospital
IAC Hemodialysis and Employer’s Grievance ONA File #201404972

We are counsel to the Ontario Nurses’ Association in respect of the Independent Assessment Committee hearing for the Dialysis Unit. We write this letter in response to the letter which you received from Hospital counsel, Mr. Green, dated September 12, 2014.

Mr. Green suggests the IAC process should be adjourned pending the resolution of a grievance filed by the Employer. Please be advised that ONA strongly opposes any adjournment of the IAC proceedings which have been established for some time. We disagree that the Hospital’s grievance should take precedence over or derail the IAC process. We also disagree that an arbitrator is the appropriate body to determine your jurisdiction. That is a decision for you to make.

As Mr. Green advises, the parties have not settled the Employer’s grievance and it will proceed in due course through the arbitration process. This will take some time. We have asked the Employer for particulars of their grievance which, based on what we have been told, appears to have no merit. It is our position that the IAC need not concern itself with the arbitration proceedings which are separate and apart from the proceedings of the IAC.
In the meantime, we would urge you to proceed as scheduled with the Independent Assessment Committee hearing. If there are any issues with respect to your jurisdiction we assume they can be dealt with at the outset of the hearing which is scheduled to commence on November 24, 2014.

Yours very truly,

CAVALLUZZO SHILTON MCINTYRE CORNISH LLP

Elizabeth J. McIntyre

Copy – Jason Green
Copy – Sharan Basran
Appendix 5: Letter from Legal Counsel of Hospital October 4, 2014

File No. 631-490
October 4, 2014

VIA EMAIL

Ms. Leslie Vincent
Chair, IAC Panel
716 Windermere Avenue
Toronto, Ontario M6S 3M1

Dear Ms. Vincent:

Re: Humber River Hospital and Ontario Nurses’ Association (ONA)
Dialysis IAC

We are in receipt of Ms. McIntyre’s letter of September 25, 2014 and can advise you that the Hospital fundamentally disagrees with the position taken by ONA.

As you are likely aware, the Independent Assessment Committee (IAC) is a process defined under Article 8 of the collective agreement between the Hospital and ONA. To the extent the Committee has any jurisdiction over workload concerns, it must be found within the language of Article 8.

A review of that article makes it clear that an Independent Assessment Committee hearing is the final step in a thorough process that is designed to address workload complaints that a nurse (or nurses as the case may be) genuinely believes negatively impacts proper patient care. These concerns are to be addressed by both the nurse and the Hospital at the earliest possible opportunity.

In order to achieve the goal of a timely resolution, the Article sets out a number of mandatory steps that nurses must take in advancing their complaints. It is patently clear on the face of the language that an Independent Assessment Committee can only be convened once the previous steps have been taken and no resolution of the workload complaints achieved.

In the case of the workload complaints that ONA is attempting to place in front of this panel, there are numerous breaches of the procedural requirements of Article 8. In the Hospital’s view, these breaches are significant and prevent ONA from referring the workload complaints to an IAC.
The breaches committed by the individual nurses and ONA in the advancing of these workload complaints are violations of the clear language of the collective agreement. In that regard, the Hospital has filed a grievance, as we previously advised, and intends to proceed to arbitration on the basis that this panel has not been properly convened pursuant to Article 8.

The Labour Relations Act, 1995 and the collective agreement are absolutely clear that any and all disputes regarding the collective agreement must be resolved by way of grievance arbitration. To that end, Article 7.01 provides as follows:

For purposes of this Agreement, a grievance is defined as a difference arising between the parties relating to the interpretation, application, administration or alleged violation of the Agreement including any question as to whether any matter is arbitrable. [Emphasis added]

Further, Article 7.11 provides:

For all other grievances, including those grievances dealing with nursing practice issues and those agreed to be central rights issues, the matter shall be determined by a three (3) person Board of Arbitration... [Emphasis added]

There is simply no doubt that the issue raised in the Hospital's grievance is a matter to be resolved by statutory arbitration.

While it is open to this panel to render an opinion on its jurisdiction having considered the submissions of both parties, the final word on the matter must be determined by a board of arbitration.

In those circumstances it makes no sense to continue with the scheduled IAC hearing dates until this grievance has been determined and the IAC panel's jurisdiction clearly identified by an arbitrator.

To be clear, the Hospital has tremendous respect for this panel and welcomes the panel's recommendations on legitimate workload concerns that remain unresolved once the process identified in Article 8 has been exhausted. However, based on prior experience, the Hospital is aware that ONA has used the IAC process for purposes other than those intended.

In short, it is the Hospital's view that ONA is not approaching this proceeding in good faith or with any regard to the mandatory procedure set out for advancing legitimate workload concerns.

The Hospital is as concerned with proper patient care as ONA and its nurses are. However, if these IAC proceedings are to be productive, it is imperative that they deal
only with issues that have been properly raised and not resolved through the process identified by Article 8.

To the extent there are any issues that remain once that process has been completed, the Hospital welcomes this panel’s expertise on steps that can be taken to address patient care concerns.

However, in the interim, the Hospital requests that the panel adjourn the currently scheduled dates.

Please feel free to contact me directly if you have any questions.

Yours very truly,

Jason Green

c: E. McIntyre
Appendix 6: Letter from IAC Chair October 14, 2014

Leslie Vincent RN  
Consultant  
716 Windermere Ave., Toronto, ON, M6S 3M1

October 14, 2014

VIA EMAIL

Dear Ms. McIntyre and Mr. Green,

I am in receipt of the letter from Ms. McIntyre, dated September 25, 2014; and the letter from Mr. Green, dated October 3, 2014.

While the members of the Independent Assessment Committee are prepared to proceed with IAC hearing on November 24-26, 2014, it is clear that the Hospital and the Association are at odds regarding the timing of the IAC given the current grievance regarding the IAC process.

As I have previously communicated, I believe the Hospital and the Association need to resolve your issues regarding the grievance and the timing of the IAC hearing. The IAC panel will not be deciding on the merit of this grievance as we do not have this responsibility as our mandate; nor do I think we should be placed in a position to be mediating between the two parties regarding this dispute.

I look forward to hearing the outcome of your discussions.

Sincerely,

Leslie Vincent

CC.

Mariana Markovic, Ontario Nurses Association  
Doug Anderson, Ontario Nurses Association  
Marg Czau, Humber River Hospital  
Treva McCumber, Hospital Nominee, IAC  
Angela Preocanin, ONA Nominee, IAC
Appendix 7: Letter from Legal Counsel for Association October 31, 2014.

CAVALLUZZO

October 21, 2014

By E-mail: lesvincent@sympatico.ca and leslie.vincent@utoronto.ca

Leslie Vincent
Chair, IAC Panel
716 Windermere Ave.
Toronto ON M6S 3M1

Dear Ms Vincent:

Re: Ontario Nurses’ Association and Humber River Hospital
IAC Hemodialysis and Employer’s Grievance ONA File #201404972

Further to your letter of October 14th, 2014, we thank the Committee for agreeing to proceed with the IAC hearings as scheduled for November 24-26, 2014. As suggested, we will continue to work with the Employer to resolve the Employer’s grievance through the process set out in the Collective Agreement. In the meantime we will be prepared to proceed with the IAC hearings.

Yours very truly,

CAVALLUZZO SHILTON MCINTYRE CORNISH LLP

Elizabeth J. McIntyre
EJM@mcm
Copy – Jason Green
Copy – Sharan Basran, Sherry Street, Mariana Markovic, Doug Anderson, ONA
Copy – Marg Czau, Humber River Hospital
Copy – Treva McCumber, Hospital Nominee, IAC
Copy – Angela Freccarini, ONA Nominee, IAC

CAVALLUZZO SHILTON MCINTYRE CORNISH LLP BARRISTERS & SOLICITORS
474 Bathurst Street, Suite 300, Toronto, Ontario M5T 2S9 T. 416.964.1115 F. 416.964.5896 cavalluzzo.com
Appendix 8: Letter from Legal Counsel for Hospital October 23, 2014.

File No. 631-490
October 23, 2014

VIA EMAIL

Ms. Leslie Vincent
Chair, IAC Panel
716 Windermere Avenue
Toronto, Ontario M6S 3M1

Dear Ms. Vincent:

Re: Humber River Hospital and Ontario Nurses' Association (ONA)
Diabetes IAC

We are in receipt of Ms. McIntyre’s letter of October 21, 2014.

With respect, it was clear in your letter of October 14, 2014 that you directed the parties to first resolve the issues raised in the Hospital’s letter to you. Accordingly, we understood that you would be proceeding with the hearing as scheduled only if you heard further from the parties. The Union appears to have either ignored or missed this point.

In the Hospital’s view, until its grievance challenging the jurisdiction of this panel to preside over workload complaints that are in violation of the collective agreement is resolved, the IAC process cannot move forward in a way that brings meaningful resolution to legitimate issues, if they in fact exist.

In circumstances such as ours, where the panel may only issue non-binding recommendations, it is not appropriate to proceed with the hearing when the party expected to consider implementing those recommendations has expressed significant concern about the legitimacy of the process.

The Hospital will continue to attempt to resolve the jurisdictional issues with the Union. However, given it is likely necessary to proceed to arbitration to obtain the resolution, we would again request that the panel adjourn until such time as the jurisdictional issues have been clarified.
Please feel free to contact me directly if you have any questions.

Yours very truly,

[Signature]

Jason Green

c: E. McIntyre
Appendix 9: Letter from IAC Chair November 4, 2014.

Leslie Vincent
716 Windermere Ave, Toronto, ON, M6S 3M1
Phone: 416-767-8773
E-mail: lesvincent@sympatico.ca

November 4, 2014.

Ms. Mariana Markovic
Ontario Nurses’ Association
85 Grenville Street, Suite 400
Toronto, Ontario, M5S 3A2

Mr. Jason Green
Hicks Morley Hamilton Stewart Storie LLP
77 King St. W., 39th Floor, Box 371, TD Centre
Toronto, ON, M5K 1K8

Dear Ms. Markovic and Mr. Green,

I am in receipt of letters from Ms. McIntyre, dated October 21, 2014; and Mr. Green, dated October 23, 2014. Despite considerable efforts encouraging the parties to resolve the procedural issues in dispute, we find ourselves at an impasse regarding the dates to convene the Independent Assessment Committee for the Hemodialysis Unit at the Humber River Hospital.

With regret, I am canceling the planned IAC dates of November 24–26, 2014 and will proceed to find a new date for the IAC in 2015. I would expect that we convene the IAC before the end of February 2015, and I will proceed to determine the availability of the IAC panel members.

Sincerely,

[Signature]

Chair, Independent Assessment Committee for Humber River Hospital

Copy – Elizabeth J. McIntyre, Cavalluzzo
Copy – Doug Anderson, Ontario Nurses Association
Copy – Marg Czaus, Humber River Hospital
Copy – Treva McCumber, Hospital Nominee
Copy – Angela Preocanin – ONA Nominee

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## Appendix 10: Agenda for IAC

### Agenda

**Wednesday April 20, 2016**

**Holiday Inn**  
3450 Dufferin St. Toronto, M6A 2V1  
Room TBD

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tbody>
<tr>
<td>09:00 – 10:00</td>
<td>IAC Panel Preparation Meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>10:00 – 12:00</td>
<td>Tour of Dialysis Unit at Humber River Regional Hospital</td>
<td>IAC, HRRH and ONA</td>
</tr>
<tr>
<td>13:00 — 13:15</td>
<td>Introduction and Review of Proceedings by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>13:15 — 14:45</td>
<td>Ontario Nurses’ Association Submission Presentation</td>
<td>IAC, HRRH and ONA</td>
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<tr>
<td></td>
<td>Response to questions of clarification from:</td>
<td></td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
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<tr>
<td></td>
<td>• Humber River Regional Hospital</td>
<td></td>
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<td>14:45 — 15:00</td>
<td>Break</td>
<td>All</td>
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<td>15:00 — 16:30</td>
<td>Humber River Regional Hospital Submission Presentation</td>
<td>IAC, HRRH and ONA</td>
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<td></td>
<td>Response to questions of clarification from:</td>
<td></td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
<td></td>
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<tr>
<td></td>
<td>• Ontario Nurses' Association</td>
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<td>16:30</td>
<td>Review of Process for Thursday, April 21, 2016</td>
<td>IAC Chair</td>
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<td>Adjournment of Hearing</td>
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## Agenda
**Thursday April 21, 2016**

**Holiday Inn**
3450 Dufferin St. Toronto, M6A 2V1
Room TBD

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<thead>
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<th>Participants</th>
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<tr>
<td>09:00 – 12:00</td>
<td>Humber River Regional Hospital Response to Ontario Nurses’ Association Submission</td>
<td></td>
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<tr>
<td></td>
<td>Response to questions from</td>
<td>IAC, HRRH and ONA</td>
</tr>
<tr>
<td></td>
<td>• Independent Assessment Committee</td>
<td></td>
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<tr>
<td></td>
<td>• Ontario Nurses’ Association</td>
<td></td>
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<tr>
<td></td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>12:00 – 13:00</td>
<td>Lunch Break</td>
<td>All</td>
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<tr>
<td>13:00 – 16:00</td>
<td>Ontario Nurses’ Association Response to Humber River Regional Hospital</td>
<td>IAC, HRRH and ONA</td>
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<tr>
<td></td>
<td>Response to questions from</td>
<td></td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Humber River Regional Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>16:00 - 16:15</td>
<td>Review of Process for Friday, April 22, 2016</td>
<td>IAC Chair</td>
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<td>Adjournment of Meeting</td>
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<tr>
<td>16:15 onwards</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
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## Agenda

**Friday, April 22, 2016**

**Holiday Inn**

3450 Dufferin St. Toronto, M6A 2V1

Room TBD

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<th>Participants</th>
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<tr>
<td>09:00 — 12:00</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>IAC, HRRH and ONA</td>
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<tr>
<td>12:00 — 12:30</td>
<td>Closing Remarks and Identification of Next Steps by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>12:30</td>
<td>Closure of Hearing</td>
<td>All</td>
</tr>
<tr>
<td>12:30 — 14:30</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
</tr>
</tbody>
</table>
Appendix 11: Data Request to Hospital

Information Request to Humber River Hospital for IAC

**1. Unit and Patient Information (since 2013)**
   a. Types of treatment provided by Hemodialysis Unit
   b. Annual patient volumes by type of treatment and any acuity measures that are utilized
   c. Description of any workload or measurement tool used to assess nursing workload

**2. Unit Organization**
   a. Organizational chart of nursing in Hemodialysis unit
      i. Role descriptions for Team Leader/Charge Nurse or other formal nursing leadership roles below level of Manager
      ii. Role description for Manager
   b. List of other professionals who work regularly in the unit to supporting direct and indirect patient care (e.g. allied health, dialysis assistants, renal technologists, clerical staff etc.)
   c. Job descriptions of staff that directly support dialysis (e.g. dialysis assistants, renal technologists).
   d. Description of how Hemodialysis unit is organized; areas and functions.
   e. Number of chairs/stretchers in unit (physical capacity); number in operation and staffed;
   f. Master Schedule; copy of last six posted schedules; copy of a daily assignment sheet
   g. Clinical policy regarding actions to be taken if volumes exceeds capacity; including any procedures/policies regarding calling in additional staff because of high volumes
   h. Indicators being utilized to evaluate efficiency and effectiveness of the Hemodialysis unit

**3. Professional Practice**
   a. Outline of orientation program for new nursing staff in the hemodialysis unit (length and outline of content)

   a. Budgeted FTEs
   b. Active full time, part time, casual, agency FTEs (total paid hours in FTEs);
   c. Number of FT, PT, Casual positions (i.e. head count)
   d. Sick time in FTES
   e. Overtime in FTEs; percentage of OT on weekends if possible

**5. Other Staffing Information**
   a. Turnover rate for RNs for last 3 years
b. Job posting information or requirements

c. Experience profile - Average years of experience in unit; number of junior staff (less than 2 years’ experience)

d. Number and type of positions posted in the current fiscal year; and current vacancies

e. Number of nursing staff on modified work; or have permanent accommodations

6. Other
   a. Copy of local collective agreement;
Appendix 12: Attendees at the IAC

Association Attendees:

Mariana Markovic, RN, Professional Practice Specialist, LRO, ONA
Danielle Bisnar, Legal Counsel for ONA
Mike Howell RN, Bargaining Unit President, Local Coordinator
Sheri Street RN, Labour Relations Officer, ONA
Elizabeth Astillero RN, Hemodialysis
Anne Gibb RN, Hemodialysis
Nadine Cruickshank RN, Professional Practice Specialist, LRO, ONA

Observers
Vicki McKenna, RN, ONA 1st Vice President

Hospital Attendees:

Marg Czaus, Chief Nursing Officer
Scott Jarrett, Vice President, Patient Services
Karen Adams, Vice President, Human Resources and Organizational Effectiveness
Melanie Tremblay, Director, Nephrology
Dilshad Pirani, Manager, Nephrology
Marisa Vaglica, Director, Professional Practice
Jennifer Duteau, Clinical Practice Leader
Sarah Eves and Kathyrn Bird, Legal Counsel for the Hospital
### RN and RPN Staffing in Hemodialysis Unit in April 2016

(Monday to Friday)

<table>
<thead>
<tr>
<th>Hour of Day</th>
<th>M-F Staffing Pattern</th>
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<tbody>
<tr>
<td>7-8</td>
<td>RN 700-1500</td>
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<tr>
<td>9</td>
<td>RN 700-1700</td>
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<tr>
<td>10</td>
<td>RN 1500-2300</td>
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<tr>
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<td>RN 1300-2300</td>
</tr>
<tr>
<td>12</td>
<td>RN 1300-2300 Off Unit</td>
</tr>
</tbody>
</table>

**Total RN/RPN Unit:**
- RN: 21
- RPN: 14
- Total: 35

**Total Staff:**
- 21
- 21
- 21
- 21
- 21
- 21
- 21
- 21

**Notes:**
- New RNs not in numbers
- Staff come on 8 hr shift change
- Staff leave at 700
- RN come on at 700
- RPN come on at 1500
- Staff leave at 300
### Appendix 14: RN and RPN Staffing in Hemodialysis Unit in April 2016 (Saturday and Sunday)

**Staffing Pattern**

<table>
<thead>
<tr>
<th>Hour of Day</th>
<th>RN 0700-1500</th>
<th>RN 1500-2300</th>
<th>RN 1300-2300 Off Unit</th>
<th>Total RN</th>
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<td>22</td>
<td>3</td>
<td>7</td>
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</table>

**Total RN/RPN Unit**

| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

**Total Staff**

| 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

**Resource Nurse**

| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**Charge Nurse**

| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**New Numbers Staff Come On Shift Change**

| 8 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |

**Staff Leave**

| 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |

**Add 1 RN April 4 NEW**

| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**Resource Nurse**

| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**Charge Nurse**

| 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |