Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Endoscopy Program
(Finch and Church Street Sites)
Humber River Hospital

and

Ontario Nurses' Association

July 25, 2014

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July 25, 2014

Dear Ms. Czaus and Ms. Markovic

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee which 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 Registered Nurses working in the Endoscopy Unit (Finch and Church sites) at Humber River Hospital.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Hospital, the Ontario Nurses' Association & Registered Nurses from the Endoscopy Unit (Finch & Church Street Sites) to prepare and present information and respond to our questions prior to and during the three day hearing.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions that underlie a Professional Workload Complaint. The Report includes a number of unanimously submitted recommendations which we hope will assist all parties to mutually agreeable resolutions with regards to nursing workload issues on the Endoscopy Units (Finch and Church Sites).

Sincerely,

Claire Mallette RN PhD
Chair, Independent Assessment Committee

Barbara Steed RN, MN
Humber River Hospital Nominee

Cindy Gabrielli RN (EC) MScN
Ontario Nurses' Association Nominee

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PART I: INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

- **Part I Introduction**

  Outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC's jurisdiction as outlined in the Collective Agreement, and presents the Pre-Hearing, Hearing and Post-Hearing processes; as well as extensive communication prior to the hearing regarding matters relevant to the hearing.

- **Part II Presentation of the Professional Responsibility Workload Complaint**

  Presents the context of practice relating to the professional workload complaint in the Endoscopy Units (Finch and Church Sites) at Humber River Hospital; briefly summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association ('the Association'), Humber River Hospital ('the Hospital') at the Hearing.

- **Part III Discussion, Analysis and Recommendations**

- **Part IV Summary and Conclusions**

- **Part V References and Appendices**

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Endoscopy Unit at both the Finch and Church sites of the Humber River Hospital. The Association stated the following in the pre-hearing brief:

Ontario Nurses' Association (ONA) submits this Professional Responsibility Complaint as a result of the employer, Humber River Hospital, assigning a number of patients and patient workloads to individual RNs, and a groups of RNs working in the Endoscopy Units at both the Finch and Church Sites. The Employer implemented a change in Model of Care and staffing levels such that RNs have cause to believe they are being asked to perform more work than is consistent with proper patient care

ONA and management have discussed the concerns linked to this Professional Responsibility Complaint at HAC since 2011. Three Sub-HAC meetings have also taken place in attempt to resolve workload issues since that time. During the several meetings from 2012 to August 2013, ONA and the Hospital made the attempt to address the 118 Professional Responsibility Workload Report Form identified by the RNs working within the Church and Finch Street sites in the Endoscopy Unit.

ONA referred the Associations' Professional Responsibility Complaint to the Independent Assessment Committee (IAC) in a letter dated November 13, 2013 requesting the IAC to assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent and professional care in a quality practice setting according to the nursing practice standards[1]

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)
- *i) at the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources*
- *ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.*
- *iii) Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with her or his manager or designate on the next day that the Manager (or designate) and the nurse are both working or within five (5) calendar days whichever is sooner. Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the ONA/Hospital Professional Responsibility Workload Report Form to the nurse(s) within 5 days of receipt of the form with a copy to the Bargaining Unit President.*
  When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist her/him at the meeting.
- *iv) Every effort will be made to resolve workload issues at the unit level. A Union representative shall be involved in any resolution discussions at the unit level. The discussions and actions will be documented.*
- *v) Failing resolution at the unit level, submit the ONA/Hospital Professional Responsibility Workload Report Form to the Hospital-Association Committee within twenty (20) calendar days from the date of the Manager's response or when she or he ought to have responded under (iii) above. The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the ONA/Hospital Professional Responsibility Workload Report Form. The Committee shall hear and attempt to resolve the issue(s) to the satisfaction of both parties and report the outcome to the nurse(s).*
- *vi) Prior to the issue(s) being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the issue(s) and recommendations to the Chief Nursing*

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

vii) *Any settlement arrived at under Article 8.01 (a) iii), iv), or v) shall be signed by the parties. (Article 8.01(a), (viii), (ix) and (x) and 8.01(b) applies to nurses only)*

viii) *Failing resolution of the issue(s) within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the issue(s) shall be forwarded to an Independent Assessment Committee composed of three (3) registered nurses; one chosen by the Ontario Nurses' Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair.*
If one of the parties fails to appoint its nominee within a period of forty-five (45) calendar days of giving notice to proceed to the Independent Assessment Committee, the process will proceed. This will not preclude either party from appointing their nominee prior to the commencement of the Independent Assessment Committee hearing.

ix) *The Assessment Committee shall set a date to conduct a hearing into the issue(s) within fourteen (14) calendar days of its appointment and shall be empowered to investigate as is necessary and make what findings as are appropriate in the circumstances. The Assessment Committee shall render its decision, in writing, to the parties within forty-five (45) calendar days following completion of its hearing.*

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

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

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

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

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

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

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

The IACs' jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by

both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for 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 report carries considerable weight and is accepted by the parties as a method of obtaining a final dispute resolution in these difficult areas.*[2]

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

For the Association:
Cindy Gabrieilli

For the Hospital:
Barbara Steed

Chairperson
Claire Mallette

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

On November 13, 2013 the Association sent a letter via email to Claire Mallette confirming that she would be the Chairperson of the IAC to investigate the workload complaint at Humber River Hospital and requesting an IAC be held in February 2014 (Appendix 1).

On January 13, 2014, the Association notified the Hospital and the IAC Chair via email that the Association was forwarding the Professional Responsibility Complaint to an IAC. The Ontario Nurses Association also requested that a date for the hearing be set; and also provided the name of the nominee for the Ontario Nurses Association, Cindy Gabrielli (Appendix 2).

On Wednesday January 29, 2014 the Hospital advised the Association that the Hospital's nominee was Barbara Steed.

The IAC Committee communicated via email to establish potential dates for the hearing. Proposed hearing dates were provided to the Hospital and the Association. Following discussion with both parties of their

availability for the hearing by their representatives, the IAC notified the Hospital and the Association via email on March 23, 2014 that the hearing would be held on June 18-20, 2014. In the email of March 23, 2014, Dr. Mallette also requested the pre-hearing briefs and exhibits be submitted to the panel no later than May 9, 2014 at 4:30 pm in order to inform the Committee of the issues and to allow the Committee members adequate time to prepare for the hearing. The IAC, Hospital and Association agreed that the hearing would be held at the Holiday Inn Yorkdale in Toronto.

On April 29, 2014, the Association requested the IAC and Hospital for an extension in submitting the pre-hearing briefs from May 9, 2014 to May 12, 2014. All parties consented to the extension.

On May 12, 2014, the Association submitted their Pre-hearing briefs electronically and couriered to the following:

- Claire Mallette, Chair, IAC
- Barbara Steed, Hospital Nominee
- Cindy Gabrielli, ONA Nominee
- Catherine Green, Humber River Hospital

On May 13, 2014 the Hospital had not submitted their Pre-Hearing briefs to the Committee or Association members. The Association sent an email to the Chair asking for confirmation that the Hospital had submitted a brief as they had not yet received it (Appendix 3). An email was sent to Catherine Green, the Hospital's contact, asking why the parties had not yet received the Hospital's submission and assurance on behalf of Humber River Hospital that ONA's submission would not be used to influence their submission (Appendix 4).

An email from Catherine Green from the Hospital was received on May 14, 2014 (Appendix 5). The following is an excerpt from the email:

We are endeavouring to prepare our response currently and expect to deliver it by no later than May 23, 2014. We are obviously concerned with the panel's impression that we might in any way permit the ONA brief to influence our response improperly; we assure you that is not the case.

As you will note from the ONA brief, there are a total of 152 workload complaints (our records indicate we have 124 workload complaints), that have been referred to this IAC hearing. The vast majority of them do not meet the timelines set out in the collective agreement for submission to the IAC and therefore the panel does not have, in our respectful view, jurisdiction to deal with them. Further, many of the workload issues raised seek remedies to matters that are related to labour relations rather than patient safety. Those are also outside the jurisdiction of the panel from our perspective.

The Hospital was not in a position to identify which issues would actually be put in front of the IAC panel until the ONA brief was finalized and, now that it has been, we are in a position to respond and to also raise the objections to jurisdiction that need to be dealt with first.

In the email, the Hospital did state that they would consent to ONA having the opportunity to provide a reply brief on the issues that the IAC Panel would be dealing with.

On May 15, 2014, the Committee and Association members received another email from Ms. Green. In this email, the Hospital requests clarity on how the Panel intends to address the Hospital's preliminary objections to jurisdiction. The IAC Chair, responded stating that further clarification was needed on the Hospital's request as well as how to proceed as there appeared to be a breach in the process with the Hospital not submitting a Pre-Hearing brief, nor informing the IAC prior to and/or on the agreed upon date of May 12, 2014 (Appendix 6).

The Association responded to the emails from Ms. Green with a letter from Nicole Butt M.A., LL.B, ONA's Litigation Team Leader (Appendix 7). In the letter, Ms. Butt comments on how the Employer did not offer an explanation for the failure of providing a written submission in accordance with the May 12th deadline. She goes on to state that the Hospital never contacted ONA or the IAC panel to request an extension and,

Instead it appeared as if the Hospital decided to ignore the due date, because they wanted to review ONA's submissions prior to submitting their own. ONA is concerned that the Employer is not taking these concerns seriously, that they are seeking to raise jurisdictional issues that may mire the hearing down in a discussion of procedural matters instead of addressing the substantive issues. On behalf of ONA, she requests that *the Panel not consider any preliminary and/or jurisdictional issues.*

On May 20, 2014, Ms. Green sent an email on behalf of Jason Green, Lawyer from Hicks Morley who was representing the Hospital (Appendix 8). In his letter his comments include the following:

There is nothing improper about the Hospital taking the position that any workload issues to be considered by the IAC panel must first have been properly raised and processed through the Article 8 procedure. Given the overriding consideration of Article 8 is the timely resolution of these concerns, it is imperative that ONA ensure any matters referred to an IAC are done in a timely fashion and clearly relate to issues of patient safety. To the extent it fails to have done so, the panel simply does not have jurisdiction under the collective agreement to consider the issues.

From a timing perspective, the collective Agreement mandates that a referral to the IAC must be made within 60 days of the issue being raised by the nurse or nurses on the Unit. In this case, there are total of three complaint forms that meet that requirement: nos. 52, 53, and 54 as identified in the ONA brief. In that context, the Hospital would request immediate confirmation from the panel that the only issues it will be addressing in this current IAC hearing are the specific matters identified in those three complaints and that there will be no investigation into or consideration of any matters falling outside the scope of those three forms.

The Chair reviewed both letters, spoke with both the Association and Hospital, and Panel members. Based on these discussions, the decision was made that the IAC would move forward with the expectation that the Hospital provide their documentation by May 23, 2014. The Panel discussed the jurisdictional issues

and the timeframes that should be addressed. The decision was made that while there was a discrepancy of time frames and number of Professional Responsibility Workload forms between the Association and Hospital the underlying workload themes remained the same which are:

- Adequate staffing to meet patient demands and quality care
- Workload in relation to being short staffed due to sick calls, overtime, inability to have breaks during the day, and overtime
- Nurses performing non-nursing roles such as cleaning rooms and stretchers and lack of resources for portering and flow.

On May 23, 2014, the Hospital sent their Pre-Hearing Brief electronically, and followed up with larger documents being couriered over night to the following:

- Claire Mallette, Chair, IAC
- Barbara Steed, Hospital Nominee
- Cindy Gabrielli, ONA Nominee
- Mariana Markovic, Ontario Nurses' Association

On May 26, 2014, the Chair sent an email to Ms. Green and Ms. Markovic stating that the focus of the IAC panel will only be based on the relevant issues in relation to patient safety and the ability of nurses to enact their professional responsibilities in the Endoscopy Units that resulted in the IAC being called. Jurisdictional issues would be addressed during the IAC.

The Committee held a Pre-Hearing Meeting on June 3, 2014. During this meeting the following occurred:

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

Following the meeting, the IAC Chair wrote the Association and the Hospital for the purpose of requesting additional information by the close of the Hearing (Appendix 9).

On June 9th the IAC Chair wrote the Association and the Hospital for the purpose of providing a Tentative Hearing Agenda that was finalized on June 13, 2014 (Appendix 10) and a confirmed list of Hospital and Association attendees (Appendix 11).

During the morning of June 18, 2014, the IAC were provided with an extensive tour of the Finch Site Endoscopy Unit.
On behalf of the Association on the tour and/or meeting following the tour was:

- Beverley Yannuzzi RN and Resource Nurse, Endoscopy Unit (Church Site, Humber River Hospital)
- Nancy McCarron RN and Resource Nurse, Endoscopy Unit (Finch Site, Humber River Hospital)
- Mike Howell, Local Coordinator/Bargaining Unit President, Local 68
- Mariana Markovic, Professional Practice Specialist, LRO, ONA
- Sheri Street, Labour Relations Officer

On behalf of the Hospital on the tour and/or the meeting following the tour was:

- Maryam Pourtangestani, Manager of Endoscopy
- Catherine Green, Manager Labour Relations
- Carol Hatcher, Director Acute Medicine (not present on the tour)
- Agnieezka Przywolska Clinical Practice Leader (not present on the tour)
- Christine Pacitto, Clinical Practice Leader (not present on the tour)

On the morning of June 19, 2014 the IAC were provided with an extensive tour of the Church Site Endoscopy Unit.
On behalf of the Association on the tour and/or meeting following the tour was:

- Beverley Yannuzzi RN and Resource Nurse, Endoscopy Unit (Church Site, Humber River Hospital)
- Nancy McCarron RN and Resource Nurse, Endoscopy Unit (Finch Site, Humber River Hospital)
- Mike Howell, Local Coordinator/Bargaining Unit President, Local 68
- Mariana Markovic, Professional Practice Specialist, LRO, ONA
- Sheri Street, Labour Relations Officer

On behalf of the Hospital on the site tour and/or meeting following the tour was:

- Maryam Pourtangestani, Manager of Endoscopy
- Catherine Green, Manager Labour Relations
- Carol Hatcher, Director Acute Medicine (not present on the tour)
- Agnieezka Przywolska Clinical Practice Leader (not present on the tour)
- Christine Pacitto, Clinical Practice Leader (not present on the tour)

1.4.2 Hearing

The Hearing convened at 1300 hours at the Holiday Inn Yorkdale, Toronto in accordance with the Agenda (Appendix 10), the Hearing was held over three days:

Wednesday	June 18, 2014:	07:30 — 17:00 hours
Thursday	June 19, 2014:	07:30 — 17:00 hours
Wednesday	June 20, 2014:	08:30 — 12:30 hours

Participants on the respective hearing dates at the hotel are listed in Appendix 11. The Participants remained the same over all three days except for Andy Summers (ONA Board Member, Region 3) who only attended on June 18 and 20, 2014.

Wednesday June 18, 2014

The IAC arrived at Humber River Hospital Finch Site at 07:30 and were met by both Hospital and Association tour members prior to proceeding with a tour. Ms. Nancy McCarron (Resource Nurse) and Maryam Pourtangestani (Manager) facilitated the tour on behalf of the Association and the Hospital. The tour included the following areas within the department:

- Patient Registration Area
- Recovery Room
- Endoscopy Treatment Room 1
- Endoscopy Treatment Room 2
- Dirty Utility Room
- Clean Utility Room

The tour facilitated a greater understanding of the model of care and related patient flow in the Endoscopy Unit (Finch Site).

The IAC also had the opportunity to meet members from the nursing staff and physicians without Association or Hospital representatives present. In discussion with them, the IAC heard the following concerns voiced:

- Late starts and finishes;
- Changes in the Booking Elective Endoscopy Procedures and outcomes if physicians do not follow them;
- Clarity of both RN and RPN roles within the Endoscopy Unit;
- Anesthetists not always present in the procedure room monitoring the patient during the procedure;
- Staying overtime until 17:00;
- Change management plans with a senior nurse retiring shortly; and
- Performing non-nursing duties such as cleaning rooms between treatments.

Following the members who went on the tour as well as Carol Hatcher (Director Acute Medicine) and the two Clinical Practice Leaders (Agnieezka Przywolska and Christine Pacitto) met in a conference room to answer the IAC's questions. The IAC viewed this discussion as an extension of the tour as the Endoscopy Unit does not have a place where a group could ask questions in private.

The IAC began to ask questions in relation to the Clinical Practice Leader Role (CPL). Ms. Przwolska had been the CPL when the RPN role was being introduced into the Endoscopy Units, but left for a new position shortly after the RPNs began working on the Unit. Ms. Pacitto became the new CPL for the Units. Ms. Pacitto began describing her role and how she has staff meetings for 1.5 hours with the nurses on the Units once a month. The meetings are scheduled for 16:00 but don't usually start until 16:30. Nurses who stay for the meetings after their shift are paid. The meetings rotate between the Finch and Church sites.

As the Panel began to ask questions in regards to the introduction of the RPN role on the Units, Ms. Green (Manager Labour Relations) from the Hospital asked to speak with the Chair outside the room. She informed the Chair that the Hospital was requesting that the meeting be adjourned until the afternoon

hearing when all Panel members were present. Ms. Green expressed, on behalf of the Hospital that there was a concern, that if the meeting continued, information and discussions would occur without the benefit of all Panel members hearing and being able to contribute to the discussion.

Ms. Green also conveyed the concern of the Committee's request to interview a RPN who works on the Endoscopy Unit. The Hospital was worried that this may generate anxiety amongst the RPNs and create tension within the Unit. The Chair reassured Ms. Green that the IAC only wanted to speak with a RPN to gain a better understanding of the Endoscopy team and how it functions. The IAC believed it was important to interview all integral members of the team including a RN, Physician, and RPN. The IAC was concerned that not interviewing a RPN could lead to the impression that the RPN role was not valued within the Unit.

At the end of the discussion, the Chair agreed to adjourn the meeting until the afternoon hearing, but she informed the Hospital that the Committee would still interview an Endoscopic RPN the following day at the Church site as well as a nurse and physician who performed high volumes of procedures.

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

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

Ms. Mariana Markovic, Professional Practice Specialist presented on behalf of the Association. The Association's presentation was based on their written Pre-hearing submission and supporting exhibits of supporting / explanatory information, as well as a summary of the Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses within the Finch and Church Street Endoscopy Programs between 2011 until the present. Ms. Markovic outlined that while the IAC was based on Professional Responsibility Workload Report forms since 2012 until the present, it was important to point out that workload issues have existed since 2011.

During the presentation the Association reaffirmed their position that the following themes consistent with the issues identified in the PRWRFs have been increasing the workload of nurses in the Endoscopy Units.

- Staffing Levels
- Nursing Workload
- Fragmented and Interrupted Care
- Float Nurse Role
- RN and RPN Practice
- Replacing "Like for Like"
- Nurse Leadership

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

Carol Hatcher, Director Acute Medicine, presented the submission on behalf of the Hospital. The content of the Hospital's presentation was based on their written pre-hearing submission. Ms. Hatcher highlighted the Hospital's belief that many of the issues in relation to the Endoscopy Units have either been addressed and/or necessary processes are being implemented to provide a workload consistent with proper patient care requirements. She then reviewed the processes that are being implemented such as a booking policy, staggered shifts for RNs, hiring of 2 anesthetists and late starts and finishes by physicians being addressed. During and following the presentation, the Hospital responded to clarification questions posted by the Association and IAC.

The IAC Chairperson adjourned the Hearing at 1700 hours. Following adjournment of Day One of the hearing, the IAC met immediately afterwards to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion on the second day of the hearing.

Thursday June 19, 2014

The IAC arrived at the Church Site to tour the Endoscopy Unit at 7:30 am for the beginning of the morning shift. Ms. Beverley Yannuzzi (Resource Nurse) and Maryam Pourtangestani (Manager) facilitated the tour on behalf of the Association and Hospital. The tour included the following similar areas within the departments as the day before:

- Patient Registration Area
- Recovery Room
- Endoscopy Treatment Room 1
- Endoscopy Treatment Room 2
- Bronchoscopy Room
- Dirty Utility Room
- Clean Utility Room
- Break Room

The IAC was also shown a schematic diagram that was on a wall of the Endoscopy Unit planned for the new hospital. Ms. Pourtangestani (Manager) described the new Unit and how discussions are underway for transition to the new Unit. The tour facilitated a greater understanding of the model of care and related patient flow in the Endoscopy Unit (Church Site).

During the tour, the IAC also had the opportunity to meet with members from the RPN, RN, and physician groups without Association or Hospital representatives present. The discussions provided similar insight for the Panel into the following practice issues:

- Increased workload and a sense the patients were on an 'assembly line';
- Clarity of roles for all healthcare team members with the change of staffing model to RNs and RPNs;
- Late starts and finishes;
- Anesthetists not always present in the treatment room throughout the procedure;
- Decreased morale;
- Staying late until 17:00;
- Non-nursing duties;
- Pressure to 'get things done quickly'; and
- Replacement staff for sick calls and their ability to only work in the recovery room and doing admissions.

Similar to the day before, those who were on the tour as well as Carol Hatcher (Director Acute Medicine) and the two Clinical Practice Leaders (Agnieezka Przywolska and Christine Pacitto) met in a conference room to answer the IAC's questions. The IAC viewed this discussion as an extension of the tour as the Endoscopy Unit does not have a private place for groups to meet. During this time, a Code Blue was called in the Unit that fostered a discussion of the Hospital's intra-hospital transport of patients for medical imaging tests and procedures. A discussion also occurred in relation to cleaning rooms in between procedures. As a result of this dialogue, the concern was raised in relation to the process of how rooms should be cleaned in between patients who potentially/or have a known infectious disease and the pressure on nurses to get the room cleaned for the next procedure.

The tour was adjourned at 11:00. The IAC had a working lunch whereby they reviewed the information gathered from both site tours.

The IAC Chairperson opened the Hearing at 13:00 welcoming everyone back. All participants were the same as the previous day, except Mr. Andy Summers, ONA Board Member, Region 3 who was absent.

Prior to the hearing commencing, both legal counsels (Mr. Green for the Hospital and Ms. Basran for ONA) presented their views on whether the release of a media release by ONA should result in the Hearing being terminated.

The IAC Chair asked the Hospital and Association representatives to return to their respective meeting rooms while the Panel deliberated on how to proceed. As a result of their discussion, the Panel made the decision to continue. The Hearing reconvened and the members were informed that the IAC Review would continue as it was important to honor the concerns and issues that had been raised and provide recommendations to enhance and improve quality patient care.

The Hearing began with Carol Hatcher providing the Hospital's response to the Association's submission and reaffirmed the Hospital's position. Members of the Hospital team participated in the discussion following as appropriate. Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, with

the Association, provided the Association's response to the Hospital's submission. Other members of the Association team participated in the discussion following as appropriate.

The IAC Chairperson adjourned the Hearing at approximately 17:00.

Following adjournment of the Hearing, the IAC had a working dinner on the evening of June 19, 2014 to again review and synthesize the information provided, and to identify key issues requiring additional clarification and their respective questions for the final day of the hearing.

Friday June 20, 2014

Hearing

The IAC Chairperson opened the Hearing at 09:00 hours, reviewed the ground rules and welcomed everyone.

Members of the IAC posed a range of questions to review issues in more detail and gaining further clarity of the issues arising from both parties' presentations. Discussion with both the Hospital and the Association took place with active participation from both parties.

The IAC Chairperson concluded the hearing by thanking Cindy Gabrielli, Association Nominee and Barbara Steed, Hospital Nominee; as well as thanking all the participants for their engagement 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 the IAC anticipated providing the final report within 45 days.

The IAC Chair closed with sharing the following consensus recommendations that would be contained in their report, acknowledging that at this time it was not an all-inclusive list:

1. Communication processes to be supported, developed and sustained to keep both nurses and management informed;
2. Appropriate skill mix, clarification of roles and responsibilities and staffing levels to provide quality safe patient care;
3. Physician driven issues that need to continue to be addressed;
4. Non-nursing roles and recommended supports; and
5. Interpersonal working relationships and implementation of the Code of Conduct when appropriate.

The IAC Chairperson closed the Hearing at approximately 12:00.

1.4.3 Post Closure of Hearing

The IAC met immediately following the hearing on Friday June 20, 2014 over a working lunch to reflect on the issues identified, confirm themes and outline how the development of the recommendations would transpire. The IAC also confirmed the date of the next face to face meeting which would occur on June 30, 2014.

The IAC met for a full day meeting on Monday June 30, 2014. At this meeting, the IAC had extensive discussion and reviewed draft recommendations and analysis. Following the face to face meeting three teleconferences occurred on July 15, 21, and 24, 2014 to discuss, make revisions and finalize the report. All members of the IAC contributed to the final version of the report. The Final Report was submitted to the Association and the Hospital on July 25, 2014.

PART II PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Information on Humber River Hospital

Humber River Hospital (HRH) is one of Canada's largest regional acute care hospitals serving a catchment area of more than 850,000 people in the northwest Greater Toronto area. The hospital currently operates on three sites with a total of 549 beds, 3000 staff, approximately 700 physicians and volunteers. HRH is affiliated with the University of Toronto and Queen's University and is Ontario's first Centre of Excellence for laparoscopic bariatric surgery. HRH's redevelopment plan was approved by the provincial government with the groundbreaking ceremony taking place in 2011. The new Humber River Hospital, planning to open in 2015, will be Ontario's first digital hospital that will be a technological and environmental showcase.[3]

HRH believes in being accountable to their community and embraces the concept that patients deserve quality, transparency and accountability from their healthcare providers. Their mission is to provide quality patient care for a diverse urban community within an ambulatory care centre and acute care hospital through a vision of reinventing patient care and optimizing health in their community.[4] This is guided by their values that the dignity, integrity, and diversity of all are respected at all times. Practices and behaviours will reflect the values of compassion, professionalism and respect. [4]

2.2 Humber River Hospital Endoscopy Units (Finch and Church Sites)

The two Endoscopy Departments are located at the Church Street and Finch Avenue locations. The Endoscopy program is Ontario's first community hospital to use an ultrasonic gastro fiberscope to diagnose and treat cancer of the esophagus, stomach, pancreas and colon. The Units are part of the in-hospital

Critical Care-Medical Program B along with Neurology, Endocrinology, and Short-term Rehabilitation specialty areas.

The number of procedures offered to the community is approximately 14,000 cases annually. In 2012-13 there were 17, 027 procedures (9028 at the Finch site and 7999 at the Church site) performed.[6] Both sites carry out upper Gastrointestinal (GI) diagnostic and therapeutic interventions such as esophagogastroduodenoscopy, PEG insertion, and polypectomy. The diagnostic lower GI procedures of colonoscopy and sigmoidoscopy and therapeutic interventions such as colonoscopy with dilation are also done at both sites. Endoscopic Retrograde Cholangio Pancreatography occurs at both sites. Motility studies are only performed at the Finch Site while Bronchoscopy's are only done at the Church site. The predominant procedures performed at both sites are colonoscopy's, followed by gastroscopy's.

All patients receive sedation. At the Finch site an anesthetist is scheduled and present for all cases. At the Church Site an anesthetist is not always scheduled. An anesthetist being present is dependent on availability.

The two sites provide Endoscopy service 9 hours a day, 5 days a week and are supported by Gastroenterology physicians and nursing on call for after hours. There are two procedure rooms at the Finch site and two procedure rooms at the Church site. The procedure rooms are booked in morning (3.5 hours) and afternoon (3 hours) blocks for outpatients (Table 1). The nurses are scheduled to work according to the number of blocks booked each day. There is an identified 45 minute block from 11:30-12:15 reserved for gastroenterologists to do inpatient scopes as required on an urgent basis. On average approximately 40 cases/day are performed at the Finch site and 30 procedures/day at the Church site. [5]

Table 1: Endoscopy Physician Blocks at Church and Finch Sites

	Monday	Tuesday	Wednesday	Thursday	Friday
Church	1 Block AM 1 Block PM	2 Blocks Am 2 Blocks PM Bronchoscopy	2 Blocks AM 2 Blocks PM	2 Blocks AM 2 Blocks PM	2 Blocks AM 2 Blocks PM
Finch	2 Blocks AM 2 Blocks PM	2 Blocks AM 2 Blocks PM	2 Blocks AM 2 Blocks PM Motility & PH Study	2 Blocks AM 2 Blocks PM	1 Block AM 1 Block PM

2.3 Context of Staffing on the Finch and Church Site Endoscopy Units

In 2011, the two Endoscopy Units were staffed with RNs when workload concerns first began to be identified. At present, one manager, Maryam Pourtangestani, provides leadership in the two Endoscopy Units in addition to Short term Rehabilitation, Neurological Assessment and Treatment Unit, Diabetic Education Centre, Medical Day Care and Urgent Medical Care.

On each of the Units there is Resource Nurse. The Resource Nurse assists the Manager in day to day operations within the Endoscopy Units. Specifically the Resource Nurse coordinates clinical activity, promotes optimal allocation of resources, acts as a resource to nursing colleagues, works with staff to ensure standards of care are met through the role modeling and consultation, promotes and maintains inter/intradepartmental communications and participates in strategies to enhance standardization of policies, procedures and processes.[6] The Resource Nurse is also responsible for any issues with equipment, and identify and resolve any process improvements.[6] The Resource Nurse does not normally have an assignment, but this can change due to the demand of patient care and staffing.

In 2013, the Endoscopy Units adopted the Collaborative Model of Care guided by the College of Nurses of Ontario Practice Guideline which focuses on high quality, safe and patient centered care. The skill mix was changed from an all RN staff to now being Registered Nurses (RN) and Registered Practical Nurses (RPN).

Nursing care begins with patient assessment in the admission area. Patient assessment and monitoring by a nurse continues in the procedure room where nurses provide further professional and highly skilled technical assistance to the physicians during endoscopic and therapeutic procedures. Post-procedure nursing care continues through to the recovery phase after transfer to the recovery area. If one procedure room is running, the staffing pattern is 3 RNs and 1 RPN. If two procedure rooms are running, the staffing pattern is 4 RNs and 2 RPNs (Table 3). At the discretion of the Resource Nurse, RPNs, are assigned either to the recovery area or the procedure room depending on the patients' acuity and needs. The number of RNs allocated/day includes the Resource Nurse.

Table 3: Daily Work Assignments within the Endoscopy Units

Assignment	Staffing Assignment 1 Procedure Room	Staffing Assignment 2 Procedure Rooms
Procedure Room	1 RPN	2 RPNs
Recovery Room Area	2 RNs	3 RNs
Resource Nurse	1 RN	1RN

In 2013-14 fiscal year, 8.38 FTE nurses worked at the Church and Finch site Endoscopy Units. The distribution is 3 Full- time RNs and 7 Part-time RNs. There are also 4 RPNs.

The Staffing Resource Centre is utilized to support short notice sick and/or absent calls. There is one RN with the experience to be assigned to the pre-procedure and recovery room area. An RN who calls in sick will be replaced by an Endoscopy RN. Similarly, a RPN who calls in sick, will be replaced by an Endoscopy RPN. If a second RN calls in sick, the Staffing Resource Centre Nurse will be called in. If a second RPN calls in sick and if no RPN is available, then an Endoscopy RN will replace the RPN.

2.4 Workload Concerns of Registered Nurses and Discussions at Hospital Association Committee

In the Association's brief it is identified that since March 2011 to the date of writing the brief, the RNs from the two Endoscopy Units reported 159 Professional Responsibility Workload Report Form (PRWRF) with the Hospital providing documentation on 119 PRWRF in the same time frame. [5-6] In the PRWRFs, nurses identified concerns relating to professional practice, patient acuity, fluctuating workload and fluctuating staffing. With the change in the Model of Care, RNs also perceived that they were being asked to perform more work than is consistent with proper patient care[7]. The following is a summary of events leading up to the IAC Hearing.

Beginning in January 2011, the Association began to identify concerns regarding the two Endoscopy Units and nursing workload. At the January 11, 2011 ONA/Hospital Association Committee Meeting (HAC), Endoscopy workload concerns were raised. At this meeting it was identified that since November 2010, Professional Responsibility Workload Responsibility forms (PRWRFs) were submitted by nurses for such issues as improper work assignments, working through breaks and overtime, and performing non-nursing roles such as emptying garbage and cleaning stretchers.

During Hospital Association Committee (HAC) meetings in 2011, ONA continues to present workload concerns such as in the June 2011 meeting, ONA discussed the PRWRFs that identified an increase in procedures, workload, sick calls and overtime. ONA is notified in July that 1 RN in each Unit will be reduced in September 2011.

In 2012 HAC meetings, ONA continues to voice concerns about workload issues. ONA Professional Practice Specialist, Mariana Markovic, also becomes involved in the HAC discussions. In February, ONA advises the Hospital of a Pre-complaint letter and requests a Sub-HAC to attempt resolution of workload concerns.

On April 13, 2012, ONA sent the Hospital a summary of the workload complaints and a list of recommendations in an attempt to resolve the inappropriate workload assignments prior to advancing the concerns to a complaint before an IAC. Both parties met to discuss the Professional Responsibility Workload Concerns. The concerns identified were the following:

- Short staffed, up to 3 casual people work at least 3 days /week;
- Utilization of causal alternates may not have necessary skills of Endoscopy staff;
- Utilization of/Introduction of RPN in the Endoscopy Unit, where previously only staffed with RNs;
- Turnover time between cases, physicians and anesthetists late starts due to late arrival into the Unit, inadequate booking time in blocks;
- Equipment issues in relation to availability, compatibility, and in need of repair;
- Paper charting/computer ease of access is time consuming;
- Patient quality of care with increasing complex patients being seen in the hospital Endoscopy Units; and
- Senior RNs are required to access the narcotic cupboard, which increases workload with the decrease in RN staff levels and introduction of the RPN role. (Appendix 12)

In the August 2012 HAC Meeting, ONA expresses concerns related to low RN staff numbers and a reverse of FT/PT split whereby there are now 3 FT and 7 PT RN staff. The Employer shares with ONA a new Booking Elective Endoscopy Procedures Policy. The Policy outlines the block point formula, booking deadlines, and implications for physicians who run overtime during their block (Appendix 13). The Hospital also expressed a commitment to resolve workload concerns in relation to working short staffed, physicians starting/finishing late, shortage of anesthetists, increasing staffing to support bronchoscopy procedures, and letters sent to physicians who do not follow the Booking Elective Endoscopy Procedure Policy (Appendix 14).

In 2013, PRWRFs continue to be submitted with concerns of overtime, late starts/ finishes, and short staff due to sick calls. In June 2013, the RNs on both Units are notified that RPNs are being introduced into the Endoscopy Unit. Following a 6 week orientation, RPNs begin working in both Units in July. In August, the third Sub-HAC meeting occurs prior to advancing the complaint to an IAC Review. The Agenda for the meeting submitted by the Hospital identified the 5 themes to be discussed were:

- Working short staffed;
- Physician's starting late;
- Physician's finishing late;
- Shortage of anesthetists in the Endoscopy Units; and
- Bronchoscopy's

The Hospital informed ONA that they would not discuss the introduction of RPNs in to the Endoscopy Units at the meeting.

On August 26, 2 FT RNs in the Endoscopy Unit are laid off. On September 30, 2013, ONA's Professional Practice Specialist, Mariana Markovic, communicates to the Chief Nurse Executive, Marg Czaus, the Union's decision to advance the workload complaint to a Hearing before an IAC panel.

Part III: Discussion Analysis and Recommendations

Part III of the IAC Report is the analysis and discussion of workload and related issues that are impacting workload in the Endoscopy Units at Humber River Hospital. The IAC identified from the Hearing and submitted documents that the key issues are:

- Staffing
- Roles and Responsibilities
- Processes
- Communication
- Collaborative Working Relationships
- Safety
- Leadership

- Education
- Change Management

3.1 STAFFING

According to the Canadian Nurses Association the organization is obligated to provide staffing plans that ensure safe and efficient quality care for the patients it serves. This includes having the appropriate number of staff positions and competencies to ensure safe, competent and ethical care[8]. This involves having the right staff member in the right role at the right time. The Canadian Health Services Research Foundation Report on Staffing for Safety (2006), highlighted the importance of appropriate nurse resources as essential for patient health, safety and wellbeing. Alongside appropriate nurse resourcing is the need to focus on the delivery and management of health services [9]. Through examination of the data presented to the IAC, it is the Committee's belief that staffing resources are inadequate at both Endoscopy sites.

The IAC also identified that nurses are performing non-nursing roles such as cleaning stretchers and rooms in between procedures, emptying linen, stocking rooms and portering patients. In a study by Aiken et al (2001) it was found that non-nursing tasks caused an increase in workload. This has the potential of nurses being unable to focus on nursing activities resulting in negative outcomes for the patient and their family due to a decrease in quality nursing care[10].

Recommendation 1: Addition of One Fulltime RN Monday-Friday at Each Site

The panel recommends that one additional RN position be scheduled regularly from Monday to Friday at each site. This additional nurse will allow the Resource Nurse to provide leadership and perform the charge nurse duties outlined in the Resource Nurse Job Description[11] without an obligation to also provide direct patient care on a regular basis.

The Resource Nurse's role is described as being responsible and accountable for coordinating safe patient care in the Endoscopy Clinic (Finch and Church sites). The role includes assisting the manager in day to day operations within the Endoscopy Units to ensure that patient care needs are met in the most efficient and effective manner. Specifically the Resource Nurse coordinates clinical activity, promotes optimal allocation of resources, acts as a resource to nursing colleagues, works with staff to ensure standards of care are met through the role modeling and consultation, promotes and maintains inter/intradepartmental communications and participates in strategies to enhance standardization of policies, procedures and processes. The Resource Nurse is also responsible for any issues with equipment, and to identify and resolve any process improvements.[6]

There is an expectation that the Resource Nurses possesses the abilities, skills, competencies and knowledge to assume patient care at any level of the Endoscopy Clinic.[6] While the Resource Nurse should not normally have a patient assignment so that she/he can perform the leadership role, this often does not occur due to the demand of patient care and staffing and with the change of staffing skill mix to a RN and RPN model. The Resource Nurse is now being required more often to assist in procedures when the

patient's complexity changes, cover staff for breaks and replace sick calls, when a replacement staff is not available. The additional nurse would enable 1 RN being in each of the procedure rooms. This would then decrease the need for the Resource Nurse to provide direct patient care as frequently. Additional details will also be provided under the section "Roles and Responsibilities".

Recommendation 2: Employer Review Distribution of Staggered Shifts

It is recommended that the Hospital consider further staggering of a shift to either start earlier at 7 am or finish later at 17:00.

This recommendation is based on the Panel consistently hearing that overtime is most often 30 minutes past the end of the shift. Nurses spoke to the panel of how they found it difficult to plan their personal commitments with the uncertainty of not knowing whether they will have to stay overtime. As well the Panel heard that the Resource Nurse has many activities to perform at the beginning of the day including deciding on patient assignments, stocking rooms, and assisting in preparing the Unit for the day's procedures. Some RNs, when in the Resource Nurse Role and particularly at the Finch site, choose to come in at 7:00 even though it is not an expectation of the Hospital in order to perform these duties so that the beginning of the day unfolds in a timely and organized manner.

The Hospital provided the Panel with data comparing overtime hours for the two Endoscopy Units in the 6 month period from January to June in 2012, 2013 and 2014. In 2012, overtime hours for this time frame were 270 hours, 2013 it was 136 hours and in 2014 nurses worked 71.50 in overtime. The Hospital is to be commended that the decrease of overtime hours can be attributed to the introduction of strategies such as staggered shifts with the last one being from 8:30-4:30, the Booking Elective Endoscopy Procedures Policy (Appendix 13) and performance managing physicians who do not follow the procedure (Appendix 14).

While the overtime hours have markedly decreased with the introduction of these strategies, based on the calculations that 71.50 overtime hours in 2014 is approximately 12 hours/month of overtime. The Panel was told that on average the nurse is staying 30 minutes overtime, which means that there are still approximately 24 times/month that a RN is required to stay until 17:00. With the present staffing model of RNs and RPNs, only RNs can stay overtime to care for recovering patients if a procedure runs late.

> This recommendation should be considered in conjunction to work being done to improve late starts and late finishes. The introduction of a shift from 9:00-17:00 would alleviate overtime hours even more. The organization needs to be cognizant, however, that extending a shift until 17:00 should not allow physicians to go over booking times an additional 30 minutes resulting in overtime now going until 17:30.

Recommendation 3: Proactive scheduling of an RN for the Procedure Room When Anesthetist not Scheduled or Present

The IAC heard from various team members that the second room at Church site is not routinely staffed by an Anesthetist. The second room is not on the Anesthesia Pick List and is only chosen optionally by Anesthetists if they choose to work post-call. It appears that most Tuesdays and Thursdays the second room will not have an Anesthetist. The IAC recommends that until the second room at Church site becomes a standard choice on the Anesthetist Pick List that an additional RN be scheduled on the days that there will be no Anesthetist for the second room. This will ensure two nurses in the room during each procedure and allow one nurse to manage sedation and airway while the other nurse assists with the procedure.

Recommendation 4: Creation of a Dedicated "Aide" Role for the Endoscopy Units

Cleaning rooms, stretchers and equipment between patient cases is currently expected to be performed by the RN or RPN assigned to the procedure room. The IAC heard that to maintain flow and stay on time with booked cases it is difficult to properly clean the room which at times may involve cleaning of bodily fluids.

A Materials Management staff member daily stocks the main cart in each unit with supplies. Nurses are often required to porter patients and equipment to other areas/units such as ER, ICU, DI where procedures are performed because the porter cannot respond fast enough for the staff and physicians to maintain the required patient flow.

Volunteers are presently scheduled to work in the Endoscopy Unit to support staff and facilitate the efficiency of patient flow in the department. Responsibilities of the Endoscopy Volunteer outlined in the job description include activities such as assisting nurses to prepare procedure beds, run errands as requested, answer the phone, between patients and using protective gloves remove linen from the stretchers, wash mattresses with disinfectant and replace with fresh linen, accompany discharged patients to the Lounge to obtain their ride home, and assist patients to change and store clothes.[12]

While Volunteers can perform many duties of an Aide role, the Unit cannot rely on them on a daily basis due to their volunteer status. Volunteers can also refuse to do duties. For example the IAC was told that one volunteer refuses to clean beds between procedures. The Hospital provided a volunteer schedule for the Church Site that indicated presently there are unfilled blocks on Monday and Wednesday mornings and Thursday and Friday afternoons. At the Finch site there were unfilled blocks on Thursday morning and Friday afternoons. Volunteer services are not able to pull volunteers from other placements within the Hospital to meet the needs of the Endoscopy Unit. When a volunteer is not present on the Unit, nurses must perform these non-nursing duties.

Therefore, the IAC recommends the development of an Endoscopy "Aide" role. This role will be responsible for keeping carts in rooms stocked with supplies, cleaning rooms, stretchers and equipment between cases and assisting with the transfer of patients and equipment to other areas/units where

procedures are being performed. The "Aide" would take direction from the Resource Nurse regarding any other duties as required.

Recommendation 5: Morning and Afternoon Coffee Breaks of 15 min Each

The IAC heard that the majority of the nurses at both the Finch and Church site prefer to take a 30 minute coffee break in the morning and forego an afternoon coffee break. However, some nurses indicated that it potentially leaves the Unit unsafe with a continuous flow of patients into the Recovery Room and a person from one area gone for 30 minutes for a break. This is compounded if the Resource Nurse already has a patient assignment or in need of providing support during a procedure rather than relieving breaks. The IAC therefore recommends that 15 minute coffee breaks as per the collective agreement be reinstated for both the morning and the afternoon breaks.

3.2 ROLES AND RESPONSIBILITIES

Assurance of patient safety, patient flow and quality outcomes is best achieved when roles and responsibilities are clearly defined and the right person is doing the right job at the right time. In 2013 the Hospital made the decision to introduce a RN and RPN skill mix in the Endoscopy Units. This was based on the Hospital examining ways to provide safe and effective patient care while being fiscally responsible. The Endoscopy Units were identified as a potential opportunity to assess efficiency without an impact on the standard of care. After assessing the extended scope of the RPN role, the Hospital made the decision that introducing the RPN role would still provide the same patient outcomes.[6] As a result of this decision, 4 RPNs were hired to work in the Endoscopy Units while 2 FT RNs were laid off.

The RPNs underwent an extensive 6 week orientation that included:

- 3 day corporate orientation;
- 8 days of general nursing orientation specific to the Endoscopy Unit;
- 4 hours of Meditech Computer Training; and
- 3 weeks of 8 hour mentored shifts that included 6-2 hour education sessions with the Clinical Practice Leader (CPL).

The length of orientation varied based on the learner's progress, ability to meet the expectations outlined in the Competency Checklist and Mentor and CPL feedback at the discretion of the Unit Manager.

During the implementation of RPNs within the Unit, the Unit Manager, CPL, and/or Director of Professional Practice met with staff. Other activities the Management team did were:

- Daily conversations with staff including new hires, mentors, resource nurses and other staff members;
- New hires met with the CPL weekly and ad hoc to review the progress of their orientation; and
- Feedback and identified issues were addressed in a timely manner with involvement of the manager.

The College of Nurses of Ontario (CNO) Practice Guideline: RN and RPN Practice: the Client the Nurse and the Environment describes that while RNs and RPNs study from the same body of nursing knowledge, there are differences in the level of autonomous practice since RNs have a greater foundational knowledge in clinical practice, decision making, critical thinking, leadership, research utilization and resource management.[13]

The CNO highlights that making effective decisions about the appropriate nursing category to provide patient care needs be guided by the three factor framework of the client, the nurse and the environment.[13] The Client factors include:

- Complexity;
- Predictability; and
- Risk of Negative Outcomes

The more complex the client and care requirements, the greater the need for an RN to provide the full spectrum of care.[13]

Nurse Factors that impact a nurse's ability to provide safe and ethical care include:

- Leadership;
- Decision-making;
- Critical Thinking; and
- Application of knowledge

Nurses consult with others when a situation demands nursing knowledge and expertise beyond their competence. When a nurse's need for consultation exceeds the efficient delivery of care, it is most likely that an RN should be assigned to the patient.[13]

Environment factors comprise:

- Practice supports;
- Consultation resources; and
- Stability/predictability of the environment.

The less stable these factors, the greater the need for RN staffing.[13]

The three factor framework serves to assist both nurses and employers in the decision to utilize individual nurses to provide safe care to all patients.

The Panel recognizes that there is a role for the RPN in the Endoscopy department however RPN assignments must be determined using the College of Nurses Three Factor Framework. The panel heard over the course of three days that the RPN has been placed in situations of role conflict while working in the procedure room and recovery room. The panel also recognized that the RNs and RPNs within the Endoscopy Unit are performing roles better suited to support workers. The IAC recommends that role assignments change to better reflect efficiency of nursing resources and points of care where complexity is greatest to ensure patient and staff safety.

Recommendation 6: Change the Current Model of Care to Better Reflect Patient Care Needs

The IAC recommends that both sites change the role assignment as follows taking into consideration the additional RN role as outlined in Recommendation One.

- Resource Nurse – 1 RN (No Assignment)
- Procedure Rooms – 2 RNs – One in each room
- Admissions and Recovery Room – 1 RPN and 2RNs (when 2 procedure rooms are running)- similar to current state
- 1 RPN Float

The IAC heard concerns about the workload of the Resource Nurse as a result of being called into procedure rooms when RPNs felt beyond their scope of practice or comfort level in providing competent and safe care. Assigning the RN to the procedure room would result in fewer requests for assistance in the procedure room. Examples of how the RPN Float can be utilized within the unit include:

- Assigned by the Resource Nurse to assist in procedure rooms as required within their scope of practice and in collaboration with the RN in the procedure room;
- Cover for breaks for the RPN in the Admissions and Recovery Room;
- Assist in the Recovery Room to free up an RN with Phase Two patients when needed to receive a Phase One recovery patient from the procedure room;
- Assist with patient admissions when needed;
- Assist with specimen preparation for the lab when multiple specimens are being taken.

With the recommended change in the current model, the work assignment would be as outlined in Table 4. When there is a third procedure room running, an additional RN will be required.

Table 4: Recommended Daily Work Assignments within the Endoscopy Units

Assignment	Staffing Assignment 1 Procedure Room	Staffing Assignment 2 Procedure Rooms
Procedure Room	1 RN	2 RNs
Float Nurse	1 RPN	1 RPN
Recovery Room Area	2 RNs	2 RNs 1 RPN
Resource Nurse No Assignment	1 RN	1RN
TOTAL	4 RN/1 RPN	5 RN/ 2 RPN

The Manager, CPL, Resource Nurse, RNs and RPNs should collaborate and fully define any other roles for the RPN Float. It would be the role of the Resource Nurse to re-assign the RPN Float according to the changing environment or patient complexity as needed on an ongoing basis. The additional role would provide more flexibility in meeting demands of sick calls and performing procedures off the unit. This would also allow the Resource Nurse to focus on leadership and administrative duties and only be required to provide direct patient care in complex situations.

Recommendation 7: Develop and Post a List of Specific Roles and Responsibilities for the RPN and RN in the Endoscopy Unit

The IAC heard that role confusion about the RPN continues for all disciplines working within the Endoscopy units. Understanding the roles, responsibilities and decision making abilities of team members is imperative for safe patient care in rapidly changing complex environments.[14] In order to achieve this, an understanding of each other's roles, mutual respect and commitment to common goals is needed. [14]

It is recommended that the Clinical Practice Leader using the current job descriptions, the CNO 3-Factor Framework and in conjunction with RNs and RPNs from the Endoscopy units, as subject matter experts develop a clear list of roles and responsibilities for the RPN and a separate one for the RN that can be posted within each unit for easy reference on a daily basis. This will help to clear up any misunderstandings and allow real time access for decision making regarding assignments. It is also recommended that an information session be held with the physicians in the Unit and distribution of the Roles and Responsibility Information handouts so that they have an increased understanding of the differences in roles and expectations for RNs and RPNs.

Eliminating misunderstandings will further foster collaborative working relationships and teamwork within the units.

Recommendation 8: Appropriate Use of Housekeeping Services for Isolation Cleaning

When a procedure is completed for a patient with isolation precautions, nurses need to follow the Hospital isolation policies. The policy requires that the nurse call the Central Environmental Services number to request a special team who provide cleaning for isolation cases. The IAC Panel heard that staff can often wait for up to 30 minutes for this team to arrive as they are in high demand throughout the organization.

Multi-use equipment and medical devices used in such units as the Endoscopy Unit have been linked to an increased risk of infection for patients.[15] The Community and Hospital Infection Control Association (CHICA) Canada identify that hospital acquired infections as a result of care delivery procedures can result in significant adverse outcomes for patients and continue to be a risk for patient safety.[15]

The Panel recognizes that patient flow in the department may be delayed as a result of waiting for the cleaning team, but the risk of improper cleaning affecting patient safety supersedes patient flow. All staff need to follow the policy. If there is a delay and/or increase pressure to clean the room so that patient flow is not impacted, the nurses need to escalate the issue through notifying the manager and if necessary the Director, Acute Medicine. If the situation occurs after business hours, then the Program/Services Coordinator needs to be contacted. Management must support the nurses in this process and implement the Code of Conduct policy should abusive language occur from healthcare providers as a result of patient flow delays.

To facilitate an increased understanding and implementation of isolation precautions within the Unit, the Hospital could send a memo or provide an information sheet and/or workshop outlining the process to all healthcare professionals within the Endoscopy Units.

3.3 PROCESSES

Standard processes and guidelines are key elements to efficient yet safe, effective care within fast-paced ambulatory environments. These types of systematic processes are used to improve services in order to meet or exceed patient expectations in an efficient and effective way. Systematic processes can include:

- Organizational structures that identify and improve processes;
- Use of tools to examine and identify improvement in the implementation of services; and
- Empowerment of teams to identify ways to improve their work and lead the implementation of new processes[16]

Carmen et al.'s research suggest that process improvements and an empowered workforce improve patient satisfaction and improved efficiency.[16]

In the Endoscopy Units, clinical complexities and emergencies cannot be entirely planned for but routine outpatient bookings and procedures can be predicted. Based on quality and time management research in healthcare organizations, adhering to start times, finish times, appropriate booking times and proper patient preparation will vastly improve value by enhancing throughput, improving staff satisfaction, patient satisfaction and ensuring quality and safety.[16]

Recommendation 9: Establishment of a Program Evaluation Committee to Increase Effectiveness and Efficiency of Care in the Endoscopy Unit.

The Hospital provided comparative data from January to June in 2013 and 2014 that demonstrated ongoing underutilization of blocks that remained similar with only some fluctuations for both time frames. The charts submitted (Tables 6 & 7) demonstrate that blocks are consistently under-utilized by 70% on a monthly basis. On average at the Finch Site only 14 blocks had the correct allocation weighting time while 45 cases were under the assigned block allocations/month. The Church Site had similar allocations with 13 being booked correctly/month and 46 were under the allocation blocked. Only a few cases at both sites were over the blocked allocation.

Yet, the Hospital also provided statistics demonstrating an ongoing trend of late starts and late finishes. (See Tables 8 & 9). The Hospital informed the panel that there has been a significant improvement in overtime usage from 2012 at 270 hours to 71.5 hours of overtime from Jan-June in 2014. The decline in overtime can be attributed to the implementation of ongoing strategies between the Hospital's Senior Leadership team and the Chief of Endoscopy to reduce the number of late starts and late finishes.

Table 6: Finch Over/Under Block Allocations

Allocation	Jan'14	Jan'13	Feb'14	Feb'13	Mar'14	Mar13	Apr'114	Apr'13	May'14	May'13
Correct	9	16	14	16	12	15	7	18	10	23
Under	61	56	32	32	47	47	42	43	49	42
Over	1	0	3	0	3	0	0	2	2	1

Table 7: Church Over/Under Block Allocations

Allocation	Jan'14	Jan'13	Feb'14	Feb'13	Mar'14	Mar13	Apr'114	Apr'13	May'14	May'13
Correct	11	21	8	6	15	14	10	16	18	10
Under	51	48	49	52	41	44	41	39	45	51
Over	2	1	0	0	0	0	0	3	1	2

The reduction in overtime hours from 2012 to 2014 is to be commended. However, as previously discussed, with 71 hours of overtime in the past 6 months, there are approximately 12 hours of overtime/month. The Panel heard that on average the Nurses are required to stay 30 minutes overtime, which means there are approximately 24 times/ month that Nurses are required to stay late.

It order to achieve better efficiency and effectiveness in the Unit and specifically in the areas of block allocations and late start and finishes, it is recommended that an Endoscopy Program Committee be established. This Committee would be interdisciplinary with representation of all disciplines who are responsible for the care of the endoscopic patient. Membership of the Committee would minimally include the Endoscopy Manager, RN, RPN, Physician and Anesthetist. In the establishment of the Committee it is recommended that Terms of Reference be developed including ground rules, and processes identified such as the circulation of agendas, minutes and processes for the dissemination of information.

Table 8: **Finch Block Starts and Finishes**

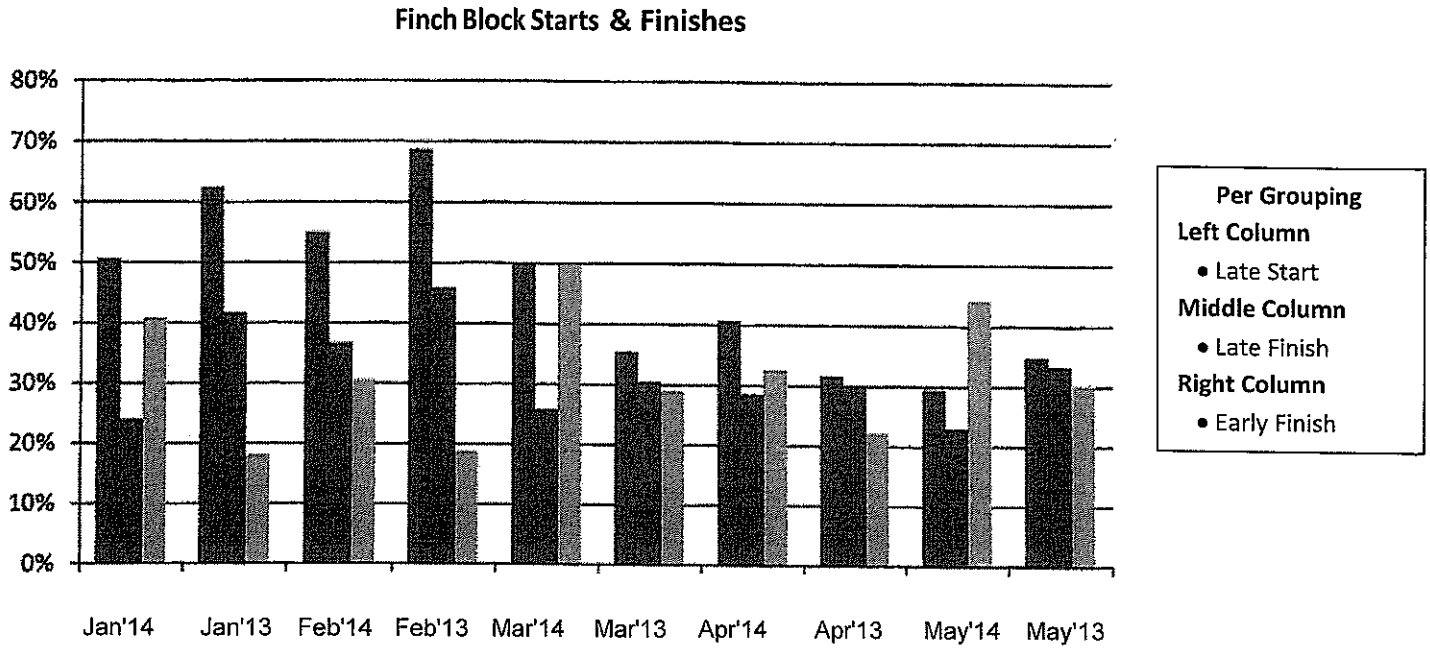
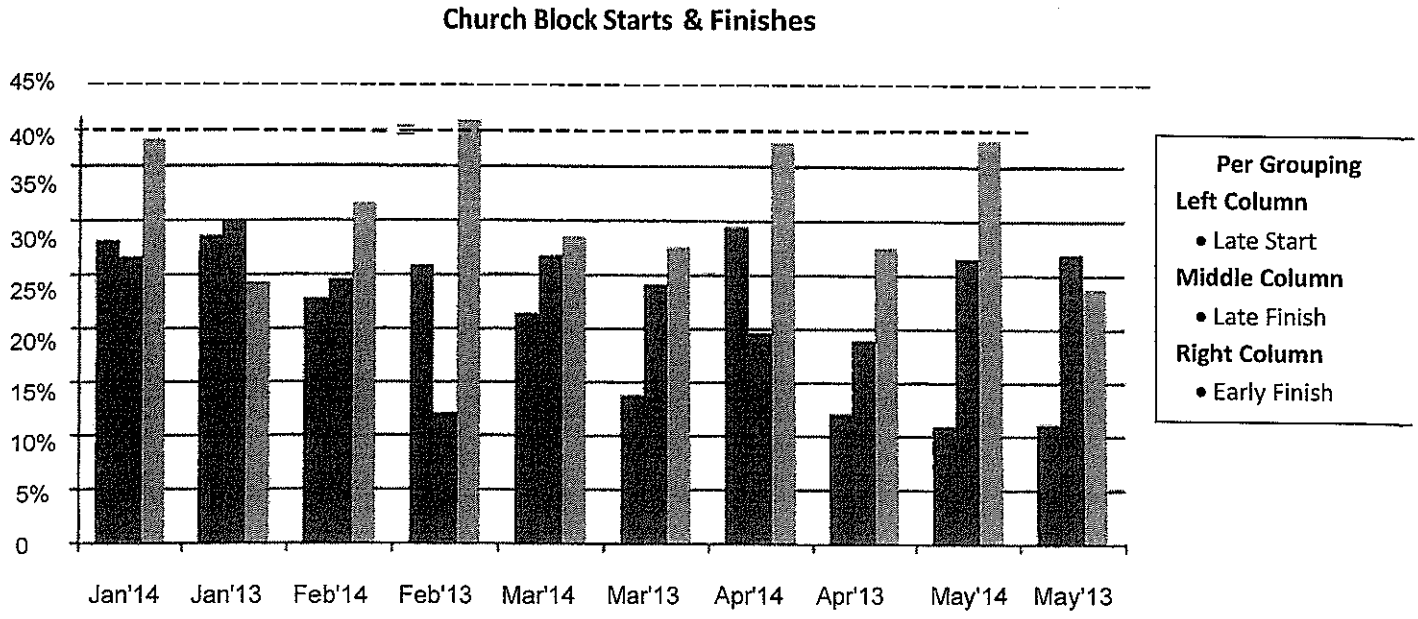


Table 9: **Church Block Starts and Finishes**



Establishing this Committee should be a priority. The Endoscopy Program Committee would examine issues in the Unit. Under their guidance and leadership they would then identify and implement ongoing, improved and new strategies to increase efficiency and effectiveness in providing quality patient care.

In regards to block allocations and reduction of overtime hours, the Endoscopy Program Committee would examine and identify better methods to estimate more accurate block allocations to decrease the number of under allocated blocks. Alongside this, system issues related to late starts and finishes would be examined. The Committee could also ensure that enforcement of established procedures to address physicians who have late starts and finishes continues and be consistently implemented. This would then lead to better understanding and identification of proper staffing needs and the elimination for the need of overtime apart from exceptional circumstances.

Recommendation 10: Implement Daily Quality and Utilization Huddles through Developing a Quality & Utilization Board

The IAC recommends the Endoscopy Unit at each site develop and implement regular, brief huddles to discuss issues and successes pertaining to quality and utilization. Huddles are being used in healthcare to improve communication and assist teams in better managing efficiencies and effectiveness of care. [17] Huddles occur when the healthcare team comes together at a predetermined time each day to examine issues related to patients, and can provide a venue for raising concerns, increase efficiency and quality. This is achieved through the exchange of critical information, and increases staff's perception of the benefits of face-to-face discussion. [17, 18]

Research findings indicate that huddles can improve patient safety and can reveal factors that contribute to potentially adverse patient outcomes, such as medication errors, near misses and poor hand hygiene.[15, 18] Moreover, huddle implementation can improve teamwork by enhancing working relationships, increasing trust across departments, and helping staff appreciate and respect others, seeing them as partners working towards a common goal.[18]

Huddles within the Endoscopy Unit could foster collaborative working relationships, empower staff and enhance teamwork. The huddles could be led on a rotating basis by the Resource Nurse, staff RNs, RPNs, Endoscopy Technician, Physicians and the Clerk. Interdisciplinary participation is essential for successful quality improvement as it fosters identification and consideration of a broader range of improvement strategies than if only one discipline was examining the issue.[19]

Huddles also provide an opportunity for proactive solutions to be trialed and provides staff with quantitative data ultimately affecting workload for decision making and eliminating perceptions based on anecdotal information. Examples of what could be tracked and monitored in the Endoscopy Units may include:

- Late starts and finishes;
- Patients arriving fully prepared;
- Patients providing detailed medication lists;
- Patients who didn't arrange a ride post procedure; and
- Patients who are NPO as required.

The data obtained through the huddles can then be tracked and monitored on a Quality and Utilization Whiteboard. Healthcare organizations are more frequently tracking this information through the use of Whiteboards that are either a dry and erase board or a computerized whiteboard.[20] The use of a Quality and Utilization Whiteboard will assist the team to set goals and stay focused on issues that are impacting the efficiency and effectiveness of the Unit. The person who will be responsible for keeping the whiteboard updated will need to be established. One suggestion could be that the staff member who has the most knowledge of a tracking item would be responsible for keeping it updated.[20] For example, the nurse doing admissions could track the patients who are fully prepared, while physicians could track their start and finish times for the day.

Computerized Whiteboards are more efficient in that the data from each day can be stored and easily accessed vs. a dry and erase board. In the planning of the new Humber River Hospital, the hospital should consider (if not already in the plans) the introduction of a computerized Whiteboard. Until the move occurs in 2015, a dry and erase board could be trialed.

Recommendation 11: Guidelines to be Developed and Followed for Calling in Staff

In the Hospital's submission to the IAC, it outlined the process for replacement of sick calls. The process outlined that a RN who calls in sick will be replaced by an Endoscopy RN. Similarly, a RPN who calls in sick, will be replaced by an Endoscopy RPN. If a second RN calls in sick, the Staffing Resource Centre Nurse will be called in. If a second RPN calls in sick and if no RPN is available, then an Endoscopy RN will replace the RPN.[6]

The challenge arises when the appropriate staffing is not available. The Resource Nurse has the responsibility of assisting the manager with staffing.[11] The Panel recommends, the Resource Nurse in collaboration with the manager develop additional methods/tools for calling in staff when there are no appropriate Endoscopy staff available. This could be achieved through the development of an algorithm which would guide the Resource Nurse to call in staff when required. The algorithm would clearly identify when to call in staff and what designation to call. There may be times within the unit where there is a case which may require 2 RN's which was not prescheduled. This tool would provide for specific parameters to assist the Resource Nurse's decision making in calling the appropriate staff members. This

would not however replace the Resource Nurse keeping the manager apprised of the situation in the Endoscopy unit.

When nursing staff are being replaced all efforts should be made to replace the absent nurse with the same category of nurse. Replacing staff for incidental illness, vacations, leaves can be challenging. The Hospital schedules Endoscopy staff before any float pool staff. When staffing from outside or within the department, the same category of nurse is to be used. This provides for safe quality care for the patients. Replacing with a lesser category only adds to the nurse's workload and may increase patient risk. If there is not a RN available to replace the absent RN, then there should be a discussion with the manager to collaboratively reach a solution on how to proceed with the day's staffing.

Recommendation 12: All Policies and Job Descriptions be Approved Prior to Posting

It became evident in the Hospital brief and at the Hearing, that some job descriptions such as the Resource Nurse and the RN specifically, were posted on the Hospital Intranet but not yet approved. This could become confusing for staff either who are in the positions or are reviewing them.

The Panel recommends that the job descriptions that have not yet been approved be approved by September 30, 2014.

3.4 Communication

Communication amongst all health care providers as well as the management team is essential. When healthcare providers do not communicate effectively, patient safety is at risk[21]. This occurs as a result of misinterpretation, lack of critical information, unclear orders and overlooked status changes[21]. In order for team members to effectively and appropriately implement their roles, individuals and teams require access to timely and relevant information.[22]

Communication is also a key factor of collaboration amongst members of the healthcare team.[14] Each team member has a responsibility to participate in communicating relevant information in relation to patient care, their role and understanding the roles of others.[14]

The organization plays an important role in facilitating collaboration and effective communication practices.[22] The research literature indicates that open channels for communication within the organization, transparency, trust and strong leadership are considered important factors in facilitating the effective flow of important information and the sharing of knowledge .[22]

Throughout the hearing, the Panel heard examples of what appeared to be communication gaps between the staff and management teams. For example, it appeared that staff were hearing for the first time that a Unit staff member was involved in the planning of the new unit. Prior to this, there was a belief amongst the point of care staff that they had not been included in the discussions. Another example was staff at the hearing expressed that they were unaware of a procedure room being closed as a result of physicians being on vacation.

Recommendation 13: Improved Communication amongst all Healthcare Providers and the Management Team

To improve communication channels amongst staff and management, strategies such as communicating clearly, regularly and equally needs to occur.[23] Communication needs to be clear and concise to ensure ambiguity or a lack of understanding does not occur. Regular communication using multiple methods such as email, face to face, and utilization of a message board facilitates ongoing updates about important information relevant to staff and the Unit.[23] As the two Endoscopy Units are presently geographically separated, management and staff need to ensure that the information is shared equally across sites. Multiple methods of communication are recommended so that there are more opportunities for staff members to be informed and information conveyed.

The Clinical Practice Leader (CPL) has initiated staff meetings once a month which are rotated between sites. These meetings are held after working hours which does not interrupt patient care or the flow of the department. The staff are paid for attending the meeting.

In a busy department with two sites, keeping up to date on issues is imperative. The IAC encourages these meetings to continue. The information discussed in the meetings and other staff meetings should be readily accessible to those staff members who are unable to attend. The move to one site in 2015, will enable the team to come together more easily for these meetings.

While this is one form of communication, other means need to be developed collaboratively and used for the exchange of information between all parties. This may include but not limited to emails, a communication board/book within the department. As well, all minutes of staff meetings should be available for staff to read.

During the Hearing, the Panel heard that both staff and management believed they had communicated information and issues to each other. Yet, the other party was unaware of it or it appeared that the concern had not been addressed. It is important that staff are made aware of how issues are being taken care of. The Panel is aware there may be confidential issues which must be maintained and respected, however, management could communicate to staff that they are addressing their concerns. This would provide the nurses with a sense of reassurance that their concerns or issues are being heard.

In order to achieve effective communication both management and staff have equal and integral roles. While it is imperative that management keeps open lines of communication, address concerns and provide up to date relevant and important information, staff also have a responsibility to take necessary measures to access information to stay informed, seek clarification if questions arise, and keep management cognizant of concerns.

Recommendation 14: Processes for Contacting the Unit Manager be Clearly Identified

The Unit Manager provides leadership in the two Endoscopy Units in addition to Short term Rehabilitation, Neurological Assessment and Treatment Unit, Diabetic Education Centre, Medical Day Care and Urgent Medical Care. She is physically located at the Church site of the Hospital. As she is responsible for multiple areas and sites, the manager carries a pager and cell phone.

During the Hearing, the Panel heard the manager tell staff that if they required her assistance they should contact her. Staff portrayed that at times she was not readily accessible, however, staff also acknowledged that there were times when they did not page the manager when they should have. While both the Manager and Director of Acute Medicine both told staff that if they had issues they should be contacted, a clear process of contacting the manager or her designate needs be developed and/or reviewed and when needed, an escalation process of who to call next.

The IAC recommends a process be developed similar to the escalation policy for the location of physicians. In this policy it is clearly outlined how staff utilize Locating to contact the physician on call through the use of a pager or cell phone. If there is not a response within 10 minutes, staff can ask Locating to page again. If there is still no response following 10 minutes, the Nursing Unit may ask Locating to initiate the Escalation Process.[23]

This policy could be used as a guideline to collaboratively develop an escalation policy or algorithm type form that the Nursing Unit could follow for Contacting Management.

Recommendation 15: Utilize Appropriate Methods of Communication to Match the Urgency of the Issue.

There are many means of communication available to staff. While the Panel heard of efforts being made by both staff and management to communicate with each other, at times the intended results were not being achieved. Management outlined that they are available by several means. The manager carries a pager, cell phone or she may be contacted by email or voicemail. The staff confirmed that the manager answers her pager within a reasonable time. The staff, however, need to decide the urgency of the call. If she/he feels the issue can wait and the answer is not imminent, then an email to the manager would be appropriate. If the issue is of a more urgent nature, then staff need to contact the manager through her pager and/or cell phone. If the manager does not respond in a reasonable time, then this would be the opportunity to use a policy or algorithm for escalating the issue.

The IAC recommends that management and staff collaboratively develop effective communication processes and determine what works best for the Unit depending on the urgency of the situation. Email is one form of communication available to all staff. Email could be used for communicating non urgent issues to the manager. The manager could also use email to keep the staff informed of relevant information. However, due to a fast paced nature and already high workload of the department, these emails may not be read on a daily basis.

Until such time as an algorithm or escalation policy for staff to follow is in place, the IAC encourages the staff to continue to page the manager for urgent issues, and email or phone message for issues that do not need to be addressed immediately.

Recommendation 16: Implementation of Article 8.01 Professional Responsibility Work Forms

The IAC recommends that management and staff collaboratively develop a communication process that can effectively and efficiently address the professional responsibility workload concerns outlined in the Collective Agreement in a timely manner.

Article 8:01 outlines the process for both staff and management to deal with workload issues/concerns. The article clearly states that at the time the workload issue occurs the process is to:

- Discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources;
- If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) who has responsibility for timely resolution of workload issues;
- 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/his manager(or designate) on the next day that the manager and the nurse are both working or within five calendar days whichever is sooner;
- The ONA/Hospital Professional Responsibility Workload Report Form (PRWRF) should be completed; and
- The manager (or designate) will provide a written response on the ONA/Hospital PRWRF to the nurse(s) within 5 days of receipt of the Form with a copy to the Bargaining Unit President.[24]

When reviewing the PRWRF submissions, it became apparent the process of filing a professional responsibility concern was not always adhered to by both parties. It is important that management are made aware of the concern by staff and given the opportunity to rectify the issue at the time of the occurrence. On the other hand, it is equally important that the manager address the issue and respond in writing on the PRWRFs within the 5 day time frame. Although the forms are part of the Collective Agreement both management and staff can use these as a form of communication to resolve ongoing issues within the Unit.

It is also recommended that regular Hospital Association Committee meetings are scheduled and held (minimum of every two months) and that a process for formal agendas and minutes is established and sustained.

Recommendation 17: Transfer of Care Communication Processes be Followed

Effective communication is imperative during a clinical handover, for example at shift changes or from one department to another.[22] Ineffective communication during a handover may lead to a failure to understand critical aspects of a patient's condition or care, delays in a patient's treatment and/or result

in adverse patient outcomes.[22] Providing tools and solutions for effective clinical handover as a means of improving patient safety and quality care are essential in delivering quality patient care.[22]

The Panel heard of occasions where the transfer of care into or within the Unit was not consistent. Examples were given where patients in the Endoscopy Unit were transferred to another care provider with no report given to the receiving staff. During any stay in the Unit a patient may be treated or cared for by a number of health care providers. The transfer of these patients and the lack of communication between providers could result in a safety risk for the patient. There should be very clear documentation and verbal communication amongst all providers.

Each healthcare provider must use their clinical judgment within the Unit to provide the appropriate information when transferring the patient to the receiving healthcare provider. The panel recommends minimally a verbal report within the Unit must be given from the transfer provider (i.e. RN, physicians, RPN), to the receiving provider. Appropriate documentation of the patient's stay in the Endoscopy Unit also needs to be completed in a timely manner.

When a patient is transferred from the Inpatient Units, the *Intra-Hospital Transport of Patients for All Medical Imaging Tests and Procedures* needs to be followed. The purpose of this procedure is to review a patient's care requirements for the safe transportation and care of the patient upon leaving and returning to the inpatient unit/Emergency Department for any testing/procedures. The primary nurse assigned to the patient is responsible to assess the care needs of the patient and whether the patient is stable and able to leave the Unit for the test/procedure. Prior to the transport of a patient for a test or procedure the *Guidelines of the Intra-Hospital Transport of Patients for All Medical Imaging Tests and Procedures* form must be completed and accompany the patient. The form includes important information such as patient demographics, falls, risk and precaution information.[25]

The IAC recommends that the Inpatient Nurse not only complete the *Intra-Hospital Transport of Patients for All Medical Imaging Tests and Procedures* Form, but also provide a verbal report to the Endoscopy Resource Nurse when there are concerns in relation to the patient's stability.

3.5 Collaborative Working Relationships

Collaboration can be defined as the process of working together to build consensus on common goals, processes and outcomes.[14] It requires an understanding of one's own role and the roles of others within the healthcare team, nonhierarchical mutual respect and trust amongst team members, a commitment to shared goals and decision making, effective communication and accountability for both the goals and each other.[14]

Collaboration amongst all healthcare providers will enable positive patient outcomes and a healthy workplace environment within the Endoscopy department. A healthy workplace is essential for nurses to provide quality patient care[26] The Endoscopy Units at both sites are small and therefore a good

collaborative relationship amongst physician, nurses, auxiliary staff and management will positively impact quality outcomes within the Unit.

Recommendation 18: Development of a Nursing Unit Professional Practice Council by November 2014

The IAC recommends that a Professional Practice Council be developed by November 2014 for the Endoscopy Unit. Professional Practice Councils can be defined as a dynamic staff-leader partnership that promotes collaboration, shared decision making and accountability for improving quality patient care, safety and fostering a healthy work environment.[26] The Council can provide an environment where professional practice issues can be addressed leading to enhanced nursing practice. Within the Council the manager and nursing staff work together towards common goals. Research has demonstrated that when nurses are supported and empowered to provide high-quality care there are improved patient outcomes, increased job satisfaction and decreased turnover.[27]

The Panel is aware that the Endoscopy Units are small, and some of the staff work at both sites. Therefore, the IAC recommends one Professional Practice Council for both Units be established recognizing that there may be site specific issues. Membership would include RN and RPN representatives and other relevant staff as well as the manager. Terms of Reference, membership, meeting frequency, and methods for information exchange with staff will need to be established. The agendas and minutes of these meeting should be made available to all staff.

The Professional Practice Council could explore but are not limited to the following suggestions:

- Review evidence based practice and best practice guidelines to address and improve practice standards and issues within the Unit;
- Develop effective communication strategies amongst all members of the healthcare team and Management;
- Identify effective change processes in preparation for moving to the new hospital; and
- Creation of a nursing journal club.

Recommendation 19: Development of an Endoscopy Program Committee

As previously discussed in Recommendation 9, the purpose of this Interdisciplinary Committee is to bring together representatives from all healthcare disciplines involved in the care of the Endoscopy patient to address and improve practice standards within the Unit. Membership of the Committee should minimally include the Endoscopy Manager, RN, RPN, Physician and Anesthetist.

Establishing this Committee should be a priority. The Endoscopy Program Committee would examine practice issues in the Unit. Under the Committee's guidance and leadership they would then identify and implement ongoing, improved and new strategies to increase efficiency and effectiveness in providing quality patient care.

Issues that could be explored but not limited to are:

- Clinical practice issues related to patient care;
- Patient care standards for the Endoscopy Patient;
- Safety and Critical Incident Issues;
- Patient flow issues;
- Block Allocations; and
- Late starts and finishes.

3.6 Safety

It is imperative patients are kept safe from harm. Patient safety is a fundamental principle in health care.[29] Adverse events may result from a variety of situations including issues in practice, fast paced nature of work, increased use of technology, products, procedures and/or systems.[35] Poor communication amongst healthcare professionals can also compromise patient safety.[30] Ineffective communication amongst healthcare team members due to such issues as lack of communicating critical information, misinterpretation of information, or overlooked changes in status can place the patient at risk.[21]

Recommendation 20: Transfer of Care from the Procedure Room to the Recovery Room is from RN to RN or Anesthetist to RN

It is important to note with conscious sedation or any type of sedation, patient response may be immediate or delayed. The transfer of care from the procedure room to the recovery area within the Endoscopy Units should be from RN to RN or Anesthetist to RN unless the patient is not sedated and/or within the RPN's scope of practice.

There are two phases of recovery following receiving an anesthetic. Phase I post anesthesia occurs immediately following surgery and administration of sedation/analgesia and/or anesthetic agents/techniques.[31] When the patient is in this phase, the nurse focuses on life sustaining needs as the patient may be hemodynamically unstable, require supplemental oxygen, and/or require nausea interventions. [32] In Phase II, the patient requires a lower level of care and should be awake or easily arousable, hemodynamically stable and on room air with adequate O_2 saturations.[32]

Based on the College of Nurses Three Factor Framework[13] of complexity, predictability and risk of negative outcomes, the RN is required to receive and care for the patient immediately post procedure due to the complex care requirements. Once the RN has determined that the patient has moved to Phase II of recovery, the RPN can care for the patients as the RN has determined that the patient is now less complex, more predictable and at a low risk of negative outcomes.[13]

During the Hearing, it was brought to the attention of the IAC, that due to the rapid turnover and fast pace within the Unit, patients may arrive in the recovery area, and the only practitioner available to accept the patient is the RPN as the RN is accepting and caring for other patients in the area. RPNs

receiving patients in Phase I is beyond the RPN's scope of practice and places the patient and RPN at risk.

Recommendation 21: Verbal or Written Report Must Occur When Transferring the Patient from the Procedure Room to the Recovery Room

The Panel heard of occasions where the transfer of care into or within the Unit was not consistent. Examples were given where patients in the Endoscopy Unit were transferred to another care provider with no report given to the receiving staff. Ineffective communication during a handover may lead to a failure to understand critical aspects of a patient's condition or care, delays in a patient's treatment and/or result in adverse patient outcomes.[22]

As highlighted in Recommendation 15, during any stay in the Unit a patient may be treated or cared for by a number of healthcare providers. The transfer of these patients and the lack of communication between providers could result in a safety risk for the patient. There should be very clear documentation and verbal communication amongst all providers.

Each healthcare provider must use their clinical judgment within the Unit to provide the appropriate information when transferring the patient to the receiving healthcare provider. The panel recommends minimally a verbal report within the Unit must be given from the transfer provider, to the receiving provider. Appropriate documentation of the patient's stay in the Endoscopy Unit also needs to be completed in a timely manner.

Recommendation 22: Phase I and Phase II Post Anesthesia Guidelines should be Posted for all Healthcare Providers for Easy Access as a Reference

NAPN (2014)[31] has clearly defined Phase I and Phase II post anesthetic guidelines. Posting of these guidelines will aide in continuity and safe patient care. It will also provide information to guide the Resource Nurse in assigning appropriate patient assignments and evidence when challenged when the expectation occurs that an RPN receive patients who are in Phase I of recovery.

Recommendation 23: The Hospital Follows the Conscious Sedation Policy and Posts for all Staff

During the hearing the Panel heard that the staff were unable to find a policy on the care of a patient receiving conscious sedation. During and following the Hearing, the Panel requested a policy related to conscious sedation. The Panel received the policy *Adult Patient Receiving Moderate Sedation for Endoscopic Procedures, Care of* (Appendix 15) dated June 2014 via an email following the Hearing.

The policy outlines the members of the interprofessional healthcare team providing care to the patient receiving the moderate sedation that includes the gastroenterologist, nurse who assists the

gastroenterologist and the practitioner who administers the moderate sedation and monitors the patient and his/her response to the sedation throughout the procedure. If the nurse is administering the moderate sedation, she/he will have no other responsibilities during the procedure and will not leave the patient unattended or engage in tasks that will compromise continuous monitoring.[33]

As the policy submitted to the Panel had a Revised Date recorded as June 2014 and no original date of when it was first implemented, the Panel recommends that the staff be made aware of this policy. The policy should also be communicated to staff through multiple methods such as via email and be posted where they can refer to it in guiding appropriate patient care as well as justifying why a RN needs to receive patients from the procedure room, provide care until they have recovered from Phase I and the appropriate care requirements when a patient has received conscious sedation and the anesthetist is not present.

Recommendation 24: The Hospital Ensures the Anesthetist Remains in the Procedure Room at all Times during Moderate Sedation

During the Hearing, the IAC learned that on occasion the anesthetist may attend to other business within the room away from the patient or may even leave the room for periods of time. If this occurs, the nurse would not only need to perform her/his role with the gastroenterologist but would be required to provide constant monitoring of the life-sustaining needs of the patient while under anesthesia.[31]

The care of the patient receiving medications administered by the anesthetist is in all likelihood beyond the scope of the RN and most definitely that of the RPN as it is not always possible to predict how an individual will respond to receiving sedation.[34] The administration of anesthetic agents such as Propofol requires special monitoring as there is the potential for rapid and significant changes in the sedative/anesthetic depth.[34] Patients receiving moderate sedation with agents such as Propofol should receive care consistent with that of a patient receiving deep sedation.[34] The person responsible for the use of the sedation should have the knowledge and training to address the potential complications and be proficient in airway management.[34]

The patient and nurse are placed at risk if the anesthetist is not present throughout the procedure monitoring the patient for early signs of oxygen desaturation, hypotension, apnea, and level of consciousness.[34] Patient safety risks are even higher with the new practice model and introduction of the RPN role in the procedure room. If the anesthetist is not aware that a RPN is assisting the gastroenterologist instead of a RN and is not consistently monitoring the patient, the RPN does not have the same knowledge and skills to monitor and care for the airway needs of the sedated patient as a RN.

Recommendation 25: Enforcement of the Code of Conduct and if Necessary the Violence and Harassment in the Workplace Policy within the Endoscopy Unit

Humber River Hospital is committed to mutual respect amongst and between healthcare workers, the recipients of its services and visitors to the Hospital.[36] The Hospital policy on violence and harassment in the workplace and prevention outlines that all complaints and reports of abusive, aggressive and/or violent behavior will be treated seriously and will be thoroughly and fairly investigated.[36]

The Hospital also has a Code of Conduct policy. This policy is intended to promote and maintain respect, dignity, compassion, caring, teamwork, communication, professional accountability and continuous improvement within an inclusive workplace.[37] The policy identifies appropriate and inappropriate conduct. One such inappropriate conduct is that of using obscene or abusive language.

The Ontario Nurses Association conducted a survey and identified that 67% of nurses in Ontario who participated reported experiencing verbal abuse while working.[38] This type of behavior is not conducive nor acceptable for good working relationships and a healthy work environment. Research findings indicate that when violence in the workplace occurs there is increased risk of nurse absenteeism, decreased physical and mental health, and turnover.[26]

During the Hearing the Panel heard that at times abusive language was being used by healthcare providers in the Endoscopy Unit.

The Code of Conduct must be followed and enforced by all staff and physicians within the Endoscopy department. The Panel recommends that all types of unacceptable behavior be reported to the manager and escalated if necessary. There are multiple methods of addressing inappropriate behaviors. The manager must be made aware as soon as possible following the incident, for her to move forward in addressing the behavior. There may be meetings facilitated by the manager between the parties, but in all cases the method should be what makes the person feel most comfortable and safe. The issues being addressed are to be dealt with in a manner of confidentiality for all involved.

The Panel also recommends all hospital staff familiarize themselves with the Violence and Harassment in the Workplace Policy. The policy outlines the process to follow should an incident of workplace violence/ harassment be observed or experienced. The Panel encourages hospital staff to enact the policy whenever necessary.

Recommendation 26: Staff Development in Addressing Workplace Conflict

The first step in addressing workplace conflict such as abusive language is that there is an organizational commitment and willingness to address the behaviours.[21] Management needs to adhere to the processes outlined in the Code of Conduct and Violence and Harassment in the Workplace Policy and develop non-punitive practices and zero tolerance for this type of behavior.

Interactive educational sessions should be developed and provided to all members of the healthcare team on ways to foster a positive work environment, team dynamics and effective

communication strategies.[21] It is recommended that these sessions be interdisciplinary as this fosters more effective team functioning and communication.[21] The team should then collaboratively develop strategies to address how disruptive behaviours will be addressed in the Endoscopy Unit.

The Endoscopy Program Committee could lead this initiative.

3.7 Leadership

The panel is aware in today's health care environment, managers are responsible for a number of units and/or clinics and ultimately a large number of staff. The manager of the Endoscopy units at Humber River Hospital is no exception. She also has the challenge of two different sites, which moves to one in the Fall of 2015 when the new hospital opens.

The increased number of staff a manager is responsible for can contribute to a negative effect on nurse job satisfaction.[39] As the manager's span of control increases the opportunities for interaction with the staff becomes more limited. It is therefore important for nursing leadership to find methods to provide support, encouragement, positive feedback and open communication with staff members[39].

Implementation of the RNAO best practice guideline *Developing and Sustaining Nursing Leadership* includes creating an empowering work environment. An environment which is empowered has access to information, support, resources and opportunities to learn and grow that supports professional autonomy.[40]

Recommendation 27: The Manager of the Endoscopy Units Should Touch Base Daily With the Resource Nurse by Phone or Physically on the Unit.

Nurse Managers face a wide range of competing demands and priorities from staff, patients, families and the organization.[40] This becomes compounded when a manager has a large span of control and multiple sites. Managers must ultimately choose what priorities take precedence in a course of a day. In a study by Wong et al (2014) manager's identified that complex spans of control limited interactions with staff and fostered a more reactive, transactional type of leadership instead of a participative leadership approach.[42]

Point of care nurses and their leaders consistently identify communication and listening skills as attributes of an effective leader.[40] The Panel recognizes the challenges that the manager of the Endoscopy Unit faces each day, however, it is recommended that she make every effort to touch base with the Units on a daily basis either by phone or physically. One anticipates that once the two Units move to the new hospital it will be easier to be physically present on the Unit more frequently. Until the move, a daily phone call to the Resource Nurse if she cannot physically go to the Unit, would allow staff to feel that the manager is more apprised of the day to day issues and the nurses' efforts.

As previously noted, the manager is available and does respond to staff when paged. The nurses also have a responsibility in keeping the manager informed of issues within the department in a timely manner.

Recommendation 28: Creating an Empowered Work Environment in the Endoscopy Units

When nurses feel empowered within their work environment research has demonstrated that there is increased job satisfaction, increased staff motivation, improved work effectiveness, performance, and patient outcomes.[40]

Creating an empowered environment is a shared responsibility between the manager and nurses. In order to create an empowered environment structures need to collaboratively be put in place such as the Professional Practice Council, staff participating in making decisions and by optimizing opportunities for autonomy and professional growth.[40]

Roles can also be designed that have discretionary decision making ability and are relevant to key processes within the Unit.[40] The Resource Nurse role is a leadership role that assists the manager in the day to day operations of the Endoscopy Unit. With the staffing that presently exists in the Endoscopy Units, this role cannot be enacted to the full leadership capacity that is outlined in the role description. Increasing the staffing by one RN, will allow this to occur.

Working alongside the Manager, the Resource Nurse could then support and contribute to developing the nurses own point of care leadership. Leadership practices of point of care nurses are when they use knowledge and clinical expertise to effectively communicate and implement their nursing practice, question the status quo, and challenge processes.[41] Patrick et al. (2011) describes how point of care nurses can be the most significant leaders for influencing and improving direct patient care.[41]

Recommendation 29: The Hospital Fosters Leadership Support and Provides Development Opportunities for Managers

While the IAC is focused on the RNs within the Endoscopy Unit, nursing leadership is a vital element of patient care delivery and creating a healthy work environment for nurses.[40] The nurse leader facilitates the building of relationships, creating an empowering work environment, fosters a culture that supports knowledge development, and leads and sustains change.[40] The leadership characteristics of the manager can lead to a healthy work environment and healthy outcomes for the patient, nurse, team, organization and the system.[40]

The increasing size and complexity of the manager's role has been identified as contributing to stress, the sense of being overstretched, and feeling dissatisfied with the role.[42] The ability to manage one's workload remained a significant predictor of burnout in managers[41] Research

has demonstrated that leadership development results in positive outcomes in developing leadership competencies and work environments.[40]

The Panel recommends that the Hospital fosters support for their Unit Managers and leadership development.

3.8 Education

Learning organizations support work environments where staff learn together and are motivated to create, share and use knowledge in their practice.[41] Strategies that can be used to support a broad participation in knowledge development, sharing and dissemination are:

- Foster an environment where staff members can think and learn;
- Promote and support developing and using evidence based guidelines:
- Acknowledge the value of different models of knowledge generation and uptake;
- Promote and support nursing research; and
- Create opportunities for staff to assess work systems and create new ones[41]

Recommendation 30: The Clinical Practice Leader Leads Knowledge Acquisition and Evaluation of Practices with Staff in the Endoscopy Unit.

The Clinical Practice Leader (CPL) functions as the program/unit facilitator of excellence in patient centered care and nursing professional practice.[6] Part of the CPL role is to work collaboratively with Program Managers and discipline leaders to assess, plan, implement and evaluate educational programs for staff within and across programs. The CPL also provides leadership to the interdisciplinary team in the development and evaluation of clinical outcomes and standards of care.[6]

Nursing care is constantly changing within the health care environment, and the care of the endoscopic patient is no exception. Gastroenterology is a specialty within the nursing realm and nurses need to keep up to date to maintain and provide quality nursing care.

The Panel acknowledges that the CPL took a leadership role in orientating and facilitating the staffing model changes with the introduction of the RPNs into the Endoscopy Unit. Moving forward, the panel recommends the CPL continue to work with the Endoscopy nurses to assess their ongoing learning needs and provide educational activities as needed. Topics could be brought forward by the nurses and/or identified by the Resource Nurse, CPL and Manager. The newly founded Professional Practice Council could also work collaboratively with the CPL to identify and address strategies to address the nurses' learning needs.

Learning strategies that could be implemented are:

- Provide access to a variety of literature and information:
- Seek out and use subject matter experts within and external to the organization;
- Encourage collaborative problem solving;

- Establish structures and processes to encourage the discussion of issues and ideas;
- Examine the best practices of other organizations and professions;
- Engage staff in benchmarking and developing best practices; and
- Showcase successes.[41]

Recommendation 31: Ongoing Education of the Role of the RPN in the Endoscopy Unit

The CPL was fully involved in the introduction of the RPN to the Endoscopy Units. The Panel commends the leadership team for the orientation process that was implemented with the RPNs. When questioned by the IAC, the leadership team did acknowledge that they could have done more evaluation processes to assess how the staffing model was impacting on the Unit. They also acknowledged that more ongoing learning activities could have been done to better educate all disciplines to the role and scope of the RPNs in the Endoscopy Units.

There appears to still be some confusion of the scope of the RPN at this time. The Panel recommends the CPL assess staff's learning needs in regards to the role of the RPN and implement appropriate educational strategies in collaboration with the manager to relieve some of the confusion.

3.9 Change Management

The healthcare system faces constant change and challenges in meeting patient, organizational and system demands while being fiscally responsible. System changes can be difficult for staff members. Leaders can often underestimate the learning needs of staff necessary to support change.[41] When undergoing system change open communication is essential. Information should be provided to staff in multiple ways and at regular intervals. Staff should also be involved in the change process. Engagement of point of care staff should occur throughout the process to develop a shared vision and strategies to manage the change.[41]

Recommendation 32: Begin Staff Engagement Immediately in Preparation for the Move to the New Unit in Fall 2015

In Fall 2015, the two Endoscopy Units will be merging into one unit in the new hospital. The IAC heard from staff at the Hearing that they felt they had not been consulted in a meaningful way in the planning of the new unit. However, management conveyed to the Panel that they had consulted with a member of the nursing staff during the design process phase.

Moving forward, the Manager and CPL could work collaboratively with the nurses to lead the change process in preparation for the move to the new unit.

The Panel recommends that strategies to enhance engagement should begin immediately at the individual, team and organizational levels. The type of strategies that could be implemented by the Manager, CPL and Resource Nurse with the staff but not limited to are:

Individual Strategies:

- Listening to concerns of staff members;
- Addressing personal and work-related concerns;
- Providing encouragement and acknowledgement; and
- Interviewing staff and stakeholders to identify what will foster and inhibit the change process.[41]

Team Strategies

- Involving all staff;
- Creating a shared vision of what care in the new unit will look like and identifying what will be needed to achieve the vision;
- Begin skills training where necessary; and
- Explore other change initiatives within the Unit and organization to identify strategies that work well and those that were not successful.[41] An example of this would be to reflect on the strategies that were used in implementing the RPN role within the Unit. The lessons learned from this change process could be applied in preparing for the move to the new Unit.

Organizational Strategies:

- Communicate at regular intervals and frequently about the move and the strategies that are being implemented to prepare for the move;
- Multiple methods of communication should be employed such as meetings, open forums, videos, newsletters, emails, one on one meetings with staff and leaders;
- Consult and engage often with staff and unions throughout the change process;
- Use evaluation methods to evaluate the change processes, track outcomes and inform decision making.[41]

Part IV: Summary and Conclusions

The processes undertaken through this Independent Assessment Committee has provided the opportunity for an open discussion between all parties in relation to professional practice and workload issues at the Finch and Church Endoscopy Units.

The Committee has made 32 recommendations in 9 areas that have been identified through the IAC Hearing that impacts on nursing care within the Unit. The members of the IAC unanimously support all recommendations in the report. The 9 areas of recommendations are the following:

- Staffing
- Roles and Responsibilities
- Processes
- Communication
- Collaborative Working Relationships
- Safety
- Leadership
- Education
- Change Management

The Panel believes that as a result of the IAC hearing and the open discussions that occurred, the two parties can come together to implement the recommendations and achieve the common goals of quality patient care, the ability of nurses to enact their professional responsibilities and a healthy work environment.

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Appendix 1: Email from Ontario Nurses Association to C. Mallette Confirming the Chairperson of the IAC

To: "Claire Mallette
From: "Mariana Markovic"
Date: 11/13/2013 12:30PM
Cc: "Catherine Green", "Margaret Czaus"
Subject: Re: Request for IAC dates

Hi Claire,
this communication is in follow up to the request for your availability (in February, 2014), as the IAC chair, to hold a hearing.
ONA and the Humber River Hospital Employer have not made any progress in resolving the RN workload concerning professional responsibility and nursing practice in the two Endoscopy Units located on two campus sites of HRH.
I have informed the Employer's HR manager Catherine Green, and the CNO, Margaret Czaus of your availability to hold a hearing after the first week in February.
ONA is in the process of selecting our nominee and will forward the name and contact information to you. I am copying both Catherine and Marg on this email and anticipate that they will forward their nominee contact information to your attention, as well as the name of their legal counsel who will represent them at the hearing. Once we have the names of all participants it is expected that all will be included in the distribution of communication.
In due process once you have established communication with the two nominees both parties ONA and the Employer expect to be notified/consulted on the date for the hearing.

With thanks,
Mariana

Mariana Markovic RN, BScN, MN, MHSc, CHE
Professional Practice Specialist
Labour Relations Officer
Provincial Services Team
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, Ontario M5S 3A2

Appendix 2: Letter from the Association to the Hospital January 13, 2014

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

January 13, 2014

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

VIA EMAIL

Dear Ms. Czaus,

Re: Professional Responsibility Complaint in the Endoscopy Unit(s) – ONA Gel File Numbers – 201201792 and 201201793

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

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

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

Cynthia Gabrielli

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

Sincerely,

ONTARIO NURSES' ASSOCIATION

Mariana Markovic

Mariana Markovic
Professional Practice Specialist

C: Cynthia Gabrielli, ONA nominee
Catherine Green, HRRH Manager Labour Relations Scot
Jarrett, HRRH Vice President Patient Services
Michael Howell, ONA Local Coordinator
Sheri Street, ONA Labour Relations Officer
Doug Anderson, ONA Manager Provincial Services Team
David McCoy, Ontario Hospital Association

Appendix 3: ONA's Request for Employer's Submission

From: Mariana Markovic
Sent: Tuesday, May 13, 2014 1:59 PM
To: cmallett
Cc: cgabrielli; Green, Catherine; bsteed
Subject: Employer Communication

Hi Claire,

Please confirm you have received the Employer's Submission.

We, at ONA, have had no confirmation from the Employer on receipt of our submission; and we have not received the employer's submission.

Please advise.

Mariana

Appendix 4: Employer Communication Needed by May 14th

To: "Green, Catherine"
From: Claire Mallette/fs/
Date: 05/13/2014 08:16PM
Cc: "bsteed, "cgabrielli, "'Mariana Markovic'"
Subject: Employer Communication Needed May 14th.

Hello Catherine

Thanks for confirming that you received ONA's submission.

We had identified that May 12th was the day of submission of both parties documents. We have not yet received HRH's submission. Could you please respond to why we have not yet received HRH's documents, your assurance on behalf of HRH that you will not use ONA's submission provided to you in good faith to influence your submission, and that you will be sending HRH's submission to all parties tomorrow May 14th?

Thanks

Claire

Appendix 5: Hospital's Response to Submission Request

To: "Claire Mallette "bsteed,"cgabrielli, Mariana Markovic
From: "Green, Catherine"
Date: 05/14/2014 01:27PM
Subject: Response to your email from Tuesday May 13

Hi Claire

We are endeavouring to prepare our response currently and expect to deliver it by no later than May 23, 2014. We are obviously concerned with the panel's impression that we might in any way permit the ONA brief to influence our response improperly; we assure you that is not the case.

As you will note from the ONA brief, there are a total of 152 workload complaints (our records indicate we have 124 workload complaints), that have been referred to this IAC hearing. The vast majority of them do not meet the timelines set out in the collective agreement for submission to the IAC and therefore the panel does not have, in our respectful view, jurisdiction to deal with them. Further, many of the workload issues raised seek remedies to matters that are related to labour relations rather than patient safety. Those are also outside the jurisdiction of the panel from our perspective.

The Hospital was not in a position to identify which issues would actually be put in front of the IAC panel until the ONA brief was finalized and, now that it has been, we are in a position to respond and to also raise the objections to jurisdiction that need to be dealt with first.

To the extent there is any concern about the Hospital's late submission on the substantive issues, we certainly are prepared to consent to ONA having an opportunity to provide a reply brief on the issues that the Panel will be dealing with so that it has every opportunity for a fair hearing. Like ONA, the Hospital is committed to resolving workload issues under Article 8 to ensure the highest quality of patient safety but we do believe it is critical that the process requirements of Article 8 are respected and that matters considered under Article 8 properly reflect the intended purpose of that Article.

Thanks

Catherine Green RN
Manager, Labour Relations
Tel. 416-747-3780
Fax. 416-747-3758

Appendix 6: Emails from the Hospital & IAC Chair in Response to May 13 Email

To: "Green, Catherine"
From: Claire Mallette/
Date: 05/15/2014 09:15PM
Cc: "bsteed, "cgabrielli@, Mariana Markovic, "David McCoy"
Subject: FW: Response to your email from Tuesday May 13

Hi Catherine

I am concerned with your email, as it is my understanding that the IAC process is that the Employer and ONA provide responses to the original complaint that was filed and guided the decision to conduct an IAC. Each party then receives the other's response on the same agreed date. The Panel, as well as each party, then reviews each other's submissions and then during the panel review the issues are addressed and each party presents their responses to the submissions and concerns.

In your previous email you stated that "we are obviously concerned with the panel's impression that we might in any way permit the ONA brief to influence or response improperly." Yet, it appears that HRH's response is specifically related to ONA's response that was submitted on May 12th and not on the original complaint.

I am going to need to seek clarification on how to proceed as this appears to be a breach in the process. Since we have not received your response to which items HRH are even questioning, it is difficulty to comment. I would recommend that HRH work on the issues that were filed in the original complaint until such time as I receive clarification

Thanks

Claire

-----"Green, Catherine" <cgreen@hrh.ca> wrote: -----

To: "Claire Mallette , "bsteed, "cgabrielli@ , Mariana Markovic
From: "Green, Catherine" <cgreen@hrh.ca>
Date: 05/15/2014 03:39PM
Subject: FW: Response to your email from Tuesday May 13

Hi Claire,

Further to my response yesterday. We need clarity on how the Panel intends to address the Hospital's preliminary objections to jurisdiction as it influences how we prepare our substantive responses to the workload issues raised by ONA. While we are obviously very concerned that the panel has an opportunity to review our brief and prepare itself for the hearing, it is critical to the Hospital that there is clarity on what the Panel believes is at issue in the hearing.

At this stage we have raised jurisdictional concerns regarding timeliness and subject-matter of some of the issues included in the ONA brief. Further, there appear to at least 28 issue forms that were never provided to the Hospital in the first place and therefore have not been properly dealt with under the procedures set out in the collective agreement. In the circumstances the Hospital is in a very difficult

position regarding its ability to fully and fairly participate in the IAC process. We would appreciate some direction from the Panel as soon as possible in that regard.

Thanks

Catherine Green RN
Manager, Labour Relations
Tel. 416-747-3780
Fax. 416-747-3758

Appendix 7: ONA's Letter in Response to Hospital Not Submitting a Pre-Hearing Brief on May 12, 20

www.ona.org

Ontario Nurses' Association
85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2
m: (416) 964-8833 t FAX: (416) 964-8864

May 16, 2014

SENT VIA EMAIL

Claire Mallette

Dear Claire Mallette,

Re: Employer Submissions to ONA-HRH Endoscopy IAC-ONA GelFiles 201201792 and 201201793

ONA is writing in response to the Employer's failure to provide its submissions by May 12, 2014, in accordance with the agreement reached between the parties.

ONA is extremely concerned by the Employer's actions, which demonstrate flagrant disregard for the IAC Panel, the Professional Responsibility Process under the Collective Agreement, and the good faith agreement between the parties to provide their submissions on the same date to the panel.

We note that Ms. Green has not offered any explanation for the Employer's failure to provide the written submissions in accordance with the May 12th deadline. We also note that the Employ

never contacted ONA or the panel to request an extension, so that both parties could submit their submissions on a later date at the same time.

Instead, it appears the Employer decided to simply ignore the due date, because they wanted to review ONA's submissions prior to submitting their own. Although they claim that they will not rely on ONA's submissions, they have also indicated their intent to do exactly that.

This contemptuous attitude towards the IAC hearing is particularly troubling because the IAC process has been negotiated between the parties as an avenue to address professional practice concerns raised by nurses who are working in the Hospital. Such matters should be addressed in a timely and effective manner, pursuant to article 8 of the Collective Agreement. ONA is concerned that the Employer is not taking these concerns seriously, that they are seeking to raise jurisdictional issues that may mire the hearing down in a discussion of procedural matters instead of addressing the substantive issues. The focus for both parties should be to provide the panel with information to aid its investigation into the raised issues.

ONA notes that the nurses in the endoscopy unit at both the Finch and Church sites have been raising workload concerns under the Professional Responsibility Process since 2011. The concerns relate to the following issues: staffing levels, nursing workload, fragmented and interrupted care, float nurse role, RN and RPN practice, replacing "like for like", nurse leadership, and the Excellent Care for All Act, 2010. None of the issues contained in ONA's Brief should be a surprise to the Employer given the voluminous number of PRWRFs filed and the resulting discussions.

ONA is extremely worried that the hearing may be derailed by the Employer's recalcitrance. They have indicated that they "expect" to have their submissions in by May 23rd. We note that this is not a firm commitment to do so. This does not provide much opportunity for ONA to reply to the Employer's submissions, and to address any jurisdictional issues which the Employer may raise.

As such, ONA asks that the Panel not consider any preliminary and/or jurisdictional issues. The time for raising those concerns was on or before May 12, 2014. As noted above, ONA's submissions address the issues which have been brought forth by the nurses on the unit. The issues have all been discussed with the Employer. We do not believe that there were any forms which were not provided to the Employer but to the extent that there was such an oversight, we believe that the forms raise the same issues that were raised on the other 124 forms, which the Employer admittedly received.

Furthermore, any prejudice to the Employer has been cured, because they have now received those forms in advance of their submissions. They have therefore had an opportunity to provide a resolution to the issues raised on the forms, if such a resolution is forthcoming.

We look forward to your direction as to how to proceed so that the IAC hearing may continue as scheduled.

Sincerely,

per

N1 I Butt, M.A., LL.B.

Litigation Team Leader
Ontario Nurses' Association

C: Catherine Green, HRH Manager Labour Relations
Barbara Steed, Employer Nominee
Cynthia Gabrielli, ONA Nominee
David McCoy, Ontario Hospital Association
Valerie MacDonald, ONA Manager, Contract Administration and Bargaining Process

Appendix 8: Hospital's Response to ONA's May 16, 2014 Letter

icks Morley

AN RESOURCES
AND ADVOCACY

Toronto
Waterloo
London
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Hicks Morley Hamilton Stewart Storie LLP
77 King St. W., 39th Floor, Box 371, TD Centre
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JASON GREEN
jason-green@hicksmorley.com
Direct: 416.864.7337
Cell: 416.268.5180

File No. 631-468
May 20, 2014

VIA EMAIL

Dear Ms. Malette:

Re: Humber River Hospital and ONA
Endoscopy IAC Preliminary Issues

We are counsel to the Hospital in respect of the pending Independent Assessment Committee scheduled to commence on June 18, 2014.

We are responding to the concerns you raised in your email to Catherine Green of the
Hospital on May 15, 2014, as well as to the ONA letter of May 16, 2014.

As a starting point, we would emphasize that the Hospital is deeply concerned with ensuring the highest standard of patient safety and with promptly and thoroughly addressing the legitimate issues raised by any employee of the Hospital in that regard, including those raised by the ONA nurses.

However, the Independent Assessment Committee is established through the collective agreement between the Hospital and ONA and therefore 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.

In that regard, there is nothing improper about the Hospital taking the position that any workload issues to be considered by the IAC panel must first have been properly raised and processed through the Article 8 procedure.

Given the overriding consideration of Article 8 is the timely resolution of these concerns, it is imperative that ONA ensure any matters referred to an IAC are done in a timely fashion and clearly relate to issues of patient safety. To the extent it fails to have done so, the panel simply does not have jurisdiction under the collective agreement to consider the issues.

Contrary to the suggestion contained in ONA's letter of May 16, 2014, the issue of jurisdiction is not a trivial matter or something that the panel can or should ignore.

To the contrary, because the recommendations resulting from any IAC hearing are non-binding, it is imperative that both parties are satisfied that the IAC panel is properly seized of the matters it is considering if the resulting recommendations are to be properly considered for implementation.

Accordingly, the allegation by ONA that the Hospital has acted improperly in the manner in which is has presently responded to the ONA brief is unfounded.

By virtue of the Article 8 process itself, the Hospital is continuously in a position of responding to concerns of the ONA members regarding workload. In order to properly present the Hospital's position to the IAC, the Hospital has to know what the issues are and respond to them accordingly.

The ONA referral to the IAC, a copy of which is enclosed, reveals a bald allegation regarding "on-going practice and workload concerns" as the "issue" being submitted to hearing.

In the context of approximately 152 workload forms filed over the course of three years, this provides no basis upon which the Hospital can properly or fairly respond to legitimate concerns.

Further, and contrary to the allegation set out in Ms. Butt's letter of May 16, 2014, the referral to the IAC does not identify the issues she now seeks to particularize, including "staffing levels, nursing workload, replacing "like for like", nurse leadership, and the Excellent Care For All Act, 2010."

While we recognize that ONA is not particularly concerned with the Hospital having either a proper or fair opportunity to respond to legitimate concerns about patient safety in the Endoscopy unit, we trust the IAC panel hearing the matter actually is.

Therefore, now that the issues being brought forward have been identified through the ONA brief, the Hospital is raising a legitimate jurisdictional objection to both the timing and the subject-matter of the various referrals.

From a timing perspective, the collective agreement mandates that a referral to the IAC must be made within 60 days of the issue being first raised by the nurse or nurses on the Unit. In this case, there are total of three complaint forms that meet that requirement: nos. 52, 53 and 54 as identified in the ONA brief.

It is clear from a cursory review of the ONA brief that it intends to address matters relating to time periods far outside the timelines specified in the collective agreement and outside the particular concerns raised in those complaint forms.

In that context, the Hospital would request immediate confirmation from the panel that the only issues it will be addressing in this current IAC hearing are the specific matters identified in those three complaints and that there will be no investigation into or consideration of any matters falling outside the scope of those three forms.

Once that has been confirmed, the Hospital will be in a position to properly respond to the ONA submission.

Please feel free to contact me directly if you have any questions. Yours very truly,

Jason Green

Encl.

Cc: C. Green

Appendix 9: Pre-Hearing Request for Additional Information

From: Claire Mallette
Sent: Friday, June 06, 2014 11:44 AM
To: Green, Catherine; Mariana Markovic
Cc: Barbara Steed;
Subject: IAC in need of more information

Hi Catherine and Mariana

I hope this email finds you well. Cindy, Barb and I got together this week to review the documents and plan for the IAC. Catherine, based on our discussion and to have a better understanding of the processes in place that the submission states have been enacted to resolve the issues, we would like the following information on items below preferably before the IAC, but if we do not receive them, we will expect to have this information at the time of the panel.

We require the following:
Staffing:
Could you please provide since January 2014 the following data presented monthly for the two Endoscopy units
-Agency use
-Overtime
-A 12 week rotational schedule since the changes have been implemented
-2 sets of daily assignment sheets: one from March-April 2013 and the other March-April 2014
-Sick Calls – total number and average per day
-Pulling nurses and/or nursing students from another unit
-With the present staffing, how are lunches and breaks managed?
-How often are nurses leaving the endo unit to assist with procedures on other units? Who backfills on the Unit while the nurse is off the Unit?
-How are assignments changed if the patient's becomes unstable?

On Call Process
-Please provide the on call policy or process for the two units.
-How often are nurses scheduled to be on call? It would be helpful to have a 12week schedule for on call.

Booking Procedure Process
-the HRH document outlines that there is a new booking process for procedures. Please provide the booking process
-how are violations of the process by physicians being enforced? Please provide data on how often this has been enforced as a result of physicians not following the process compared to the number of times the process hasn't been followed.

Resource Nurse
-why does the resource nurse come in early on her own time to set up the rooms? Does the staffing not include time for set up of the rooms first thing in the morning?
-If a sick call occurs and cannot be replaced, does the Resource Nurse take on an assignment?
-If so, who is overseeing the Unit in this role with the resource nurse caring for patients?

Housekeeping
-It appears that nurses are doing general housekeeping duties such as cleaning rooms, stretchers. Why is this occurring? Is there cleaning staff assigned to do this? What is the policy/process on rooms being cleaned following a procedure?

RPNs
-What was the rationale that guided the change in staff mix from all RN staff to RN-RPN mix?
-Who decides the RPN assignment?
-What is the criteria and process used to determine where they can work?
-Where are they assigned?
-If an RN calls in sick, is she/he replaced by a RPN or is the policy an RN must be replaced by an RN.
-Who recovers the patient following the procedure? Are RPNs assigned patients immediately post procedure?

Communication
-What are the processes for contacting the Manager?
-What supports are in place for nurses when issues occur during the day and the Manager is not present on the Unit?

Anesthetist
-How often is there an anesthetist present for procedures?
-How does this impact on nurse staffing and their assignments?
-How are the support systems altered when an anesthetist is not present?
-Is it known ahead of time that an anesthetist won't be present or is it last minute notice?

Site Visits
-A draft agenda will follow next week; however we will be touring the Finch site on Wednesday morning and Church on Thursday. During our tour we would like to speak with members of the interdisciplinary team, for example, physicians, anesthetists, RNs, RPNs, booking staff, volunteers etc to get their perspective on the Unit and the issues.

The Panel discussed the jurisdictional issues raised at the beginning of this IAC process and what issues and time frame should be addressed. The Panel made the decision that while there is a discrepancy of time frames between ONA and HRH, the underlying themes remain the same and will need to be addressed during the IAC. Underlying themes that the panel identified through examining the documents were:
-Communication between staff and manager in a timely manner
-Violation of booking process by physicians
-Staffing-is the staffing adequate to meet the patient demands of the unit?
-Workload in relation to being short staffed due to sick calls, use of agency, overtime, inability to have breaks during the day, overtime
-Nurses preforming non-nursing roles such as cleaning rooms and stretchers and lack of resources for portering and flow.

Please let us know if there are other themes that need to be addressed. We recognize that there may be other themes related to workload and professional responsibility that may be identified during the panel hearing.

Appendix 10: IAC Agenda June 18-20, 2014

Independent Assessment Committee Hearing
Ontario Nurses' Association and Humber River Hospital
Endoscopy Units
Agenda

Wednesday June 18h 2014
Holiday Inn
3450 Dufferin Street Toronto, Ontario Canada M6A 2V1

Time	Item	Participants
07:30	Meet in Finch Street Endoscopy Unit	IAC
07:45 - 10:30	Tour of Finch Street Endoscopy Unit	IAC, HRH and ONA
10:30 – 12:00	IAC (flexible time for requested conversations with health care and administrative members and travel to Holiday Inn)	HRH and ONA
12:00 – 13:00	Lunch at Holiday Inn	IAC
13:00 – 13:10	Introduction and Review of Proceedings by Chairperson	IAC Chair
13:10 – 14:40	Ontario Nurses' Association Submission Presentation Response to questions of clarification from: • Independent Assessment Committee • HRH	IAC, HRH and ONA
14:40 – 15:00	Break	All
15:00 – 16:30	HRH Presentation Response to questions of clarification from • Independent Assessment Committee • Ontario Nurses' Association	IAC, HRH and ONA
16:30 – 17:00	Review of Process for Wednesday and the visit for Finch Street Endoscopy Unit June 19, 2014	IAC Chair
17:00	Adjournment of Hearing	IAC Chair

Independent Assessment Committee Hearing
Ontario Nurses' Association and Humber River Hospital
Agenda

Thursday June 19, 2014
Holiday Inn
3450 Dufferin Street Toronto, Ontario Canada M6A 2V1

Time	Item	Participants
07:30	Meet in Church Street Endoscopy Unit	IAC
07:45 - 10:30	Tour of Church Street Endoscopy Unit	IAC, HRH and ONA
10:30 – 12:00	IAC (flexible time for requested conversations with individual Healthcare and Administrative members and travel to Holiday Inn)	IAC, HRH and ONA
12:00 – 13:00	Lunch at Holiday Inn	IAC
13:00 – 13:05	Introduction and Review of Proceedings by Chairperson	IAC Chair
13:15 – 14:45	HRH Response to Ontario Nurses' Association Submission Response to questions from • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC, HRH and ONA
14:45 – 15:15	Break	All
15:15 – 16:45	Ontario Nurses' Association Response to HRH Submission Response to questions from • Independent Assessment Committee • HRH • Discussion	IAC, HRH and ONA
16:45 – 17:00	Review of Process for Thursday January 17th 2013	IAC Chair
17:00	Adjournment of Hearing	IAC Chair
18:30-21:00	Working Dinner	IAC

Independent Assessment Committee Hearing
Ontario Nurses' Association and Humber River Hospital
Agenda

Friday June 20, 2014
Holiday Inn
3450 Dufferin Street Toronto, Ontario Canada M6A 2V1

Time	Item	Participants
08:00 - 9:00	Working breakfast (may also be used for conversation with additional stakeholders if required)	IAC
09:00 – 1030	Questions to both Parties by Independent Assessment Committee	IAC, HRH and ONA
10:30 - 11:00	Break	All
11:00 - 13:00	Questions to both Parties by Independent Assessment Committee	
13:00 – 13:30	Closing Remarks and Identification of Next Steps by Chairperson	IAC Chair
13:30	Closure of Hearing	All
13:30 – 15:00	Independent Assessment Committee Meeting Working Lunch	IAC

Appendix 11: HRH and ONA IAC Attendee Lists

HRH IAC Attendee List

Name	Title
Catherine Green	Manager Labour Relations
Carol Hatcher	Director and Presenter
Margaret Czaus	Chief Nursing Executive
Scott Jarrett	Vice President, Patient Services
Marisa Vaglica	Director of Professional Practice
Maryam Pourtangestani	Manager of Endoscopy
Agnieezka Przywolska	Clinical Practice Leader
Christine Pacitto	Clinical Practice Leader
Jason Green	Legal Counsel, Hicks Morley

HRH ONA Attendee List

Name	Title
Mariana Markovic	Professional Practice Specialist
Sheri Street	Labour Relations Officer
Mike Howell	Local Coordinator/Bargaining Unit President, Local 68
Beverley Gilley Yannuzzi	RN, Endoscopy Unit (Church Site)
Nancy McCarron	RN, Endoscopy Unit (Finch Site)
Sharan Basran	ONA Litigation Manager
Andy Summers	ONA Board Member, Region 3

Appendix 12: Professional Responsibility Workload Concerns, April 13, 2012

Agenda Items
Endoscopy Unit(s) PRC Meeting

April 13, 2012
Professional Responsibility Workload Concerns

(submitted by ONA)

Pursuant to Article 8 of the full-time and part-time collective agreement, be advised the Association is bringing forth the issue of Professional Responsibility. The Registered Nurses working at Humber River Regional Hospital, Endoscopy Units at Church and Finch sites, Local 68, have identified ongoing workload problems as evidenced by the data submitted on Professional Responsibility Workload Report Forms.

The following concerns and resolutions are put forth by the Association in attempt to resolve the inappropriate workload assignments prior to advancing the concerns expressed to a complaint before the Independent Assessment Committee as per Article 8 of the Collective Agreement.

- Church site - 17 PRWRFs submitted up to February, 2012 (15 since September 2011)
- Finch site – 27 PRWRFs submitted up to February, 2012 (21 since October 2011)

1. Concern – short staffed, up to 3 casual people work at least two days per week

Resolution – review Endoscopy Unit RN base staff numbers for appropriate case assignment.

Rationale – RNs have identified that current staffing during a number of procedures in the rooms is not adequate to support the patient needs, physician needs (including the equipment set up and trouble shooting), and timely documentation.

2. Concern – utilization of casual alternates (no skills in Endoscopy unit), off unit staff.

Resolution – review casual and part time staff availability for sick call, vacation, etc., appropriate replacement in the unit.

Rationale - casual RN staff that are not Endo Casual staff are not familiar or knowledgeable in the use of equipment or in trouble shooting equipment at the time of use, creating additional need for unit resources and support.

3. Concern – Utilization/Introduction of RPN in the Endoscopy Unit, new practice setting previously only RN core competencies.

Resolution – review/evaluate of the patient criteria for the RPN practice, RPN role description and unit resources in accordance with the CNO's 3 Factor Framework for utilization of the RPN in this specialty practice setting, and patient and nurse outcomes.

Rationale – RNs are concerned that utilization of the RPN in the unit does not support the level of endoscopy patient complexity, and acuity needs and further fragments the nursing care in a high turnover fast moving environment with minimal RN resources available in the unit. The nature of endoscopy procedures and level of interventions contains significant level of unpredictable outcome requiring an RN immediately available. Lack of continuity in patient care is a grave issue of concern.

4. Concern - Turnover time between cases, physicians and anesthetists late starts due to late arrival into the unit, inadequate booking time in blocks, etc.

Resolution – review/evaluate booking blocks, length of case booking per physician, start time for physicians and anesthetists, start of shifts in Endoscopy, access to allied support in turnover.

Rationale – there is a sense of consistent offenders and physicians who chronically under book the time for procedures, holding up the next physicians block.

5. Concern - Equipment Issues, i.e., compatible blood pressure parts (from room to room), sat monitor availability (disposable finger units), ECG machines and leads.

Resolution – review available access to equipment, and process for repairs and replacement of equipment in the unit.

Rationale - removing and replacing BP cuffs, sat monitor, from room to room during the patients flow through the unit is time consuming and creates additional work for RNs. The monitoring equipment should be placed on the patient upon arrival and removed when they leave the unit.

6. Concern - Paper charting/computer ease of access is time consuming.

Resolution – review current and any new requirements for charting in the unit with all regular RN staff in the unit and all Endo casual RN staff.

Rationale – casual staff outside the unit are familiar with the charting and documentation and do not always have access to computer (pass access, or knowledge) to be able to work in their full capacity as a regular staff RN in the unit.

7. Concern - Patient Quality of care, healthier patients attend private clinics, heavier and complex patients are seen in the hospital Endoscopy unit(s). Number of staff RNs in the Endo unit has been decreased and number of cases has increased.

Resolution – review with Concern #1 for appropriate staffing levels in the unit to ensure that all cases are weighted for the nursing tasks with equipment and patient care needs during the procedure, including demands by the anesthetist.

Rationale – nature of interventions and invasive procedures requires that additional supports are immediately available to prevent known or anticipated potential of negative outcomes.

8. Concern – access to narcotic cupboard (code at the cupboard). Senior RNs required to access.

Resolution - review with Concern #6 to ensure that all RNs in the unit have access to narcotic access as is required throughout the day for each procedure and in emergent situations.

Rationale – the number of RN staff in the unit varies throughout the time of the day, i.e., with breaks and procedures under way.

Additional Site specific - Finch Issues/Church Issues

Concern
Finch site, registration issues in waiting for patients. Church site Same Day Surgery does the registration.

Concern
Church site has only 1 bathroom. Fire hazard one exit only. (Finch site has change stalls).

Concern
No education (CPL) support in the units.

Concern
X-ray aprons, exposure to radiation, current process for monitoring exposure unclear.

Concern
On call hours, call in during off hours.

Appendix 13: Booking Elective Endoscopy Procedures

Manual	Patient Care Manual
Section	**Bookings**
Author	MANAGER CLINICAL PROGRAMS
Approved by	**PROGRAM DIRECTOR, ACUTE MEDICINE**
References	
Date	**O:** 01/06/1999 **R: 10/09/2012**

POLICY

Version Number: 2

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BOOKING ELECTIVE ENDOSCOPY PROCEDURES

Policy Statement

This HRH policy ensures that patients are booked for Elective Endoscopy in a manner such that the GI Unit operates efficiently, with sufficient time to accommodate inpatient and Emergency cases where required.

Policy

Elective Bookings:

To book an elective procedure, physician is to provide the following required patient information to the GI Unit clerk 48 hours in advance of the procedure:

- Patient's Name
- Date of Birth
- Hospital number (if applicable)
- Procedure name and secondary minor treatment plans
- Isolation (if applicable)
- Lab work
- Special equipment requested
- Special instructions for antibiotic pre-procedure and type of sedation (conscious or Anesthetia).

Booking of Endoscopy Blocks:

The Booking office is open between 0800 and 1500, Monday through Friday

- The first procedure of the morning block will be booked at 0800 hrs
- The last procedure of the morning block will finish by 1130hrs
- The first procedure of the afternoon block will be booked at 1230hrs
- The last procedure of the afternoon block will finish by 1530hrs
  (Note: staff is available between the hours of 0730 - 1630, this includes set-up and clean up time).
- An additional 45 minutes (from 1130hr – 1215hr) will be added to the on-service Gastroenterology physician to accommodate urgent ED patients and/or inpatients. Surgical colleagues can request to

utilize a portion of this time period or use surplus time during their own block (from finishing early) thereby reducing overtime.

- If the on-service Gastroenterologist does not have a block on a given day, he/she has 3 options:
  1. Scope from 0800-0845hr, having notified the Endoscopy unit in advance and negotiated with the booked physician for the time from their block
  2. Scope from 1130-1215hr
  3. Request that a gastroenterology colleague who has a block that day scope the inpatients, after a discussion with the resource nurse whose goal is to manage patient flow
- Those patients where the scope itself will have an impact on the decision to admit or discharge the patient will be considered on a case-by-case basis by the manager, the physician and the resource nurse.
- Colonoscopies shall be booked no later than 1515 hrs
- A physician may not book procedures that will extend the block beyond the regular finishing time. (See procedural block points formula in Definition)
- Utilizing the point formula data, the booking clerk will notify the physician's office that block time is overbooked and changes are required, in advance. The Physician Director of Endoscopy& Gastroenterology, the Program Director responsible for Endoscopy Services, and the Manager of Endoscopy will review endoscopy unit utilization on a regular basis and address issues as required.
- Any endoscopist not on service who chooses to add on inpatient procedures during their block will have those cases count toward his/her block total (exception is emergency/urgent case performed by gastroenterologist on behalf of the GI physician on call).
- If a Physician's bookings are in excess of the maximum allotted case-weight points, and he/she decides to complete all cases, or if extra non-booked patients arrive prepped for procedures and the result is running over the block, the physician will receive a warning letter. Physicians working in Endoscopy will receive two warning letters in total. The physician will lose a block within the following two weeks should there be a third occurrence.
- If up booking (changing time from a single procedure to a double procedure) occurs on a regular basis, then the physician will lose a block.
- If a Physician's tardiness is noted to be a regular occurrence and results in late completion of the block, the physician will have one block cancelled.
- If a Physician is delayed due to circumstances beyond his control, he/she will not be penalized.

Booking Deadline

All bookings should be sent to the clerk 48 hours before the start of the block. This will allow for the adjustment of staff and/or the booking. Further adjustments to the list should be emailed/faxed to the clerk as soon as possible.

Cancellations

Elective cases may be cancelled through the clerk up to 24 hours prior to the procedure. At this time a patient undergoing a similar procedure which requires the same amount of procedure time may be booked.

Vacations

To allow for appropriate planning and scheduling, physicians should provide ample notification to the endoscopy clerk of vacation intentions.

Infection Prevention and Control Considerations

Patients requiring additional routine precautions will be booked for procedure in the Endoscopy and will adhere to HRH Infection Prevention and Control practices.

Definitions

Procedural block point formula:

PROCEDURE	POINTS
Colonoscopy	1
OGD	0.5
Colonoscopy and OGD	1.25
Flex Sigmoidoscopy	0.5
Flex Sig (in combo with OGD)	0.5
EUS	1.0

Formulation Rules*:

- Within a 1 hour period, the total of procedures scheduled CANNOT EXCEED a score of 3.
- In a morning block (total 3.5 hours) the total of weighted procedures CANNOT EXCEED a score of 9.5.
- In an after block (total 3 hours) the total of weighted procedures CANNOT EXCEED a score of 9.

*Please note that while these numbers represent a maximum, each physician should book appropriately to ensure that he/she finishes within the allotted block time.
The adjustment of the procedural block point formula will be determined by the Physician Director for those physicians who consistently run overtime.

*Exceptions to above formula: Bronchoscopy and ERCP

Accountability / Responsibility

GI physicians and Surgeons who do Endoscopy procedures

Documentation

None applicable to this policy

Reference Standard

Appendix 14: Letter to Physician Who Do Not Follow Booking Elective Endoscopy Procedure Policy

January 21. 2014

Dear Dr.

In reviewing the Endoscopy start and finish time, we note that you are late to start and finish your blocks which has caused staff to stay longer and we had to pay them over time. For the months of September, October and November 2013:

On Sep.23/13 you started at 12:45 hrs instead of 11:30 hrs- Finished at 16:00-Over time has been paid

On Sep 30/13 you started at12:10 hrs instead of 11:30 hrs- Finished at 16:40- Over time has been paid

On Oct. 02/13 you stared at 08:20 hrs instead of 08:00 hrs-Finished at 1245 - Over time has been paid

On Oct. 21/13 you stared at 12:05 hrs instead of 11:30 hrs-Finished at 17:30- Over time has been paid

On Nov. 14/13 you stared at 08:20 hrs instead of 08:00 hrs-Finished at 12:25- Over time has been paid

Reviewing your blocks for these three months, there are several instances where you have been late starting and/or finishing your blocks. As you are aware, policy # PC.040.1 states:

- **If a physician's tardiness is noted to be a regular occurrence and results in late completion of the block, the physician will have one block cancelled.**
- **If a physician is delayed due to circumstances beyond his control, he/she will not be penalized.**

It is our hope that you will adhere to the policy requirement of starting and finishing your blocks on time, and we ask for your cooperation and support. This is your second warning letter.

As policy states:

- **Physicians working in Endoscopy will receive two warning letters in total. The physician will lose a block within the following two weeks should there be a third occurrence.**

Sincerely,

Carol Hatcher,

Program Director
Gastroenterology

Dr. Ilan Medad,

Physician Director, Endoscopy &

C.c. Medical Affairs

Appendix 15: Moderate Sedation Policy

Manual		STANDARD OF CARE
Section		
Author	CLINICAL PRACTICE LEADER, Endoscopic Uni	
Approved by	Director of Medicine	
References		
Date	O:	Version Number: 7
	R: June 2014	

This is a CONTROLLED document. Any documents appearing in PAPER FORM should be checked against the electronic document in Policy & Procedure Manager (PPM).

ADULT PATIENT RECEIVING MODERATE SEDATION FOR ENDOSCOPIC PROCEDURES, CARE OF

Patient Focused Outcome Statement

To provide safe care to adult patients receiving moderate sedation and analgesia during diagnostic Endoscopic procedures.

The members of interprofessional health care team providing care to the patient receiving the moderate sedation will include the:

- Gastroenterologist (GI physician) who performs the diagnostic and/or therapeutic endoscopic procedure,
- Nurse who assists the Gastroenterologist in performing the procedure,
- Practitioner who administers the moderate sedation and monitors the patient and his/her response to the sedation throughout the procedure. The provider may be the Anesthesiologist and/or the Registered Nurse (RN-in the absence of the Anesthesiologist).

If the Anesthesiologist is not present, a dedicated RN will remain with the patient during the administration of moderate sedation and for the duration of the procedure. The RN will have no other responsibilities during the procedure and will not leave the patient unattended or engage in tasks that will compromise continuous monitoring.

Informed written consent from the patient will be obtained by the GI before administering moderate sedation/analgesia.

All emergency airway equipment will be immediately available during and after the administration of the moderate sedation/analgesia to support airway patency.

Interprofessional Care Team

The Care Team includes, but is not limited to, the Gastroenterologist, the Anesthesiologist, Registered Nurse, Registered Practical Nurse, and the Registered Respiratory Therapist. All staff provide care according to their professional practice standards and scopes of practice following the guidelines set out and established by Humber River Hospital's organizational policies.

Equipment

- Code Blue Crash Cart stocked with emergency and resuscitative drugs including airway management supplies with defibrillator immediately available
- 100% oxygen source and Oxygen administration supplies
- Suction equipment and suction source
- Cardiac monitor (available in the room)
- Non-invasive blood pressure monitor.
- Pulse oximeter (monitor for oxygen saturation)
- IV supplies
- Required procedural medications including necessary sedatives , analgesics and reversal agents

Assessment

Pre-procedure

1. Pre-Procedure Assessment
    - Baseline vital signs including pulse, blood pressure, respiratory rate, oxygen saturation, temperature and level of consciousness
    - Time and nature of last oral intake

2. Patient's history will be completed and documented including:

    - Medical and social history including history of tobacco, alcohol, and substance use
    - Medical, Surgical and invasive procedures history and any related complications
    - Allergies
    - Current medications including over-the-counter medication and herbal supplements/regimes
    - Previous adverse experiences with sedation/analgesia
    - Falls Risk
    - Contact with or presence of communicable diseases

3. The physician will be notified of any conditions that identify patients at high risk for developing complications in order to determine appropriate level of care and environment for safe administration of moderate sedation/ analgesia. High risk patients include but is not limited to the following conditions:

    - Morbid obesity
    - Sleep apnea
    - Patients at high risk for aspiration (full stomach, GERD, bowel obstruction)
    - Neurologically unstable patients (decreased level of consciousness, confusion, hyperexcitability)
    - Unable to follow directions
    - History of difficult intubation
    - Patients with facial, dental or airway abnormalities that would preclude tracheal intubation

4. Intravenous access will be established and maintained

5. Oxygen as ordered by the physician will be applied.

Intra Procedure:

1. Vital signs including pulse, heart rate, oxygen saturation, respiratory rate, level of consciousness and pain level will be monitored and documented within 5 minutes of moderate sedation administration, and every 5 minutes while patient is sedated (The patient's respiratory rate, heart rate and oxygen saturation should be monitored continuously)

2. Patient's response to the sedation and signs of hypoventilation will be monitored. Oxygen administration may be required if the oxygen saturation decreases below 92% or decreases by 5% from the baseline.

3. If the Anesthesiologist is not present for the procedure, the Registered Nurse will administer medication for moderate sedation as ordered when the GI physician present

   NOTE: Propofol for sedation for the endoscopic procedures must be administered only by the Anesthetist, or in an emergency situation, a second MD who is responsible for maintaining the patient's airway.

4. The medication name, dosage, time of administration, route and patient response to medication must be monitored and documented.

Post Procedure

Phase 1 of Recovery

1. Post procedure the patient will be transferred to the recovery area of the Endoscopy unit. Care should be transferred to the recovery room nurses and the physician should remain present until patient is stable and nurse accepts care.

2. The RN receiving the patient will ensure patient's safety at all times during the phase I recovery. RN will assess and document vital signs including heart rate, blood pressure, respiratory rate, oxygen saturation, level of consciousness and pain immediately post procedure and every 5 minutes x 3, then q 15 minutes x 3 **OR** until the patient is fully awake and/or returned to the pre-procedure baseline status. The GI/Anesthesia will be notified immediately of any adverse reactions.

3. The patient will be monitored until ready for discharge from Phase 1 of Recovery. Evidence for transition to phase 2 of the Recovery Phase includes:
   - Achieving a minimum score of nine on the Post Anesthesia Recovery (also known as Aldrete) discharge scoring system with a minimum score of two on the airway parameter of the discharge scoring system **(Refer to Appendix A for the *Aldrete Scoring System)***
   - Return of gag reflex

- Respiratory Symptoms that include but are not limited to: Airway patency, laryngospasm
- Recovery of any clinical parameters as indicated by the GI surgeon or anesthesiologist

Phase 2 of Recovery

4. Transfer of care from the Registered Nurse to the Registered Practical Nurse will occur when the patient has completed Phase 1 of the recovery according to the Aldrete Scoring System (**(Refer to Appendix A for the *Aldrete Scoring System)***.

5. The RPN will ensure patient's safety at all times during the phase 2 recovery until patient is ready for discharge. The RPN will assess and document vital signs every 10-15 minutes.

6. The GI/and or Anesthesia will be notified of the following based on the nursing assessment:
   - The patient does not achieve his/her pre-procedure vital signs baseline.
   - Persisting pain greater than 4/ 10 not relived by medication
   - Bleeding or unexpected drainage
   - Persisting nausea and vomiting
   - Changes in the respiratory, neurologic and / or cardiac function

7. Patients receiving Flumazenil should be monitored in endoscopy for a minimum of 2 hours from the time of administration.

8. The IV will be removed prior to discharge.

9. The patient will be monitored until ready for discharge from phase two of recovery. Evidence of discharge readiness includes achieving a minimum score of nine on the Modified Post anesthesia Discharge scoring system phase 2 of recovery and recovery of any clinical parameters as indicated by surgeon or anesthesiologist ***(Refer to Appendix B Modified Post Anesthesia Discharge Scoring System)***

10. Patients who have received moderate sedation will be discharged to or accompanied by an identified responsible adult who is able to accompany the patient home.

11. Post procedure and follow up care instructions should be provided to the patient / caregiver on discharge. Patients should be instructed not to drive, operate a machinery or power tools or make important decisions 24 hours following sedation

Note: Patient is not to operate any motor vehicles for 24 hours after the procedure.

Infection Prevention and Control Considerations

All HRH staff, physicians and volunteers shall follow Infection Prevention and Control Routine Practices and Additional Precautions as outlines in Provincial Disease Advisory Committee (PIDAC): Routine Practices and Additional Precautions, Ministry of Health and Long Term Care, 2009 as per HRH policy Routine Practices and Additional Precautions.

Definitions

Moderate sedation

- a drug induced depression of consciousness
- patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation
- no intervention required to maintain a patent airway
- spontaneous ventilation adequate
- cardiovascular function is usually maintained

Post Anesthesia Recovery Discharge Scoring System, Phase I Recovery (Aldrete)

The PARS includes five assessment parameters each rated 0 to 2 according to the degree of functional recovery from anesthesia. A score of "9" is required for discharge (Miller. 2005; D. Kamming & F.Chung. 2004; H, Ead.2006; J.Aldrete. 1998)

Modified Post anesthesia Discharge scoring system Phase 2 of Recovery

The PADSS includes five assessment parameters each rated 0 to 2 according to the degree of functional recovery from anesthesia:1) vital signs, 2) ambulation, 3) pain 4) postoperative nausea and vomiting, 5) surgical bleeding. Patients who achieve a score of 9 or greater are considered fit for discharge with a responsible escort.
(F. Chung, 1998, 2006; H. Ead. 2008; OPANA 2009;)

Discharge Criteria

Discharge criteria provide a summary of clinical observation and judgment of readiness for discharge that is applicable to all patient situations. It has medico-legal value and reflects evidence based practice. Discharge criteria allows nurses to act in the absence of anesthesia personal, ensuring the same standards of care for all patients
A numeric scoring system, when part of the discharge criteria, trends patients' progress toward discharge readiness, with greater score reflecting increased patient stability and lower risk for complications.

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Reference Standard

American Society of Anesthesiologists. (2002. Practice guidelines for sedation and analgesia by non-anesthesiologists. Anesthesiology, 96(4), pp. 1004-1017

Canadian Anesthesiologist S. (2014). Guidelines for the practice of the anesthesia. Canadian Journal of Anesthesia. 61(1).Revised edition.
Patient
Care Assessment Guidelines for Intravenous Moderate Sedation. Policy 94-004. http://www.massmedboard.org/pca/pca_intravenous.shtm

Humber River Hospital. Adult Endoscopy Patient, Care of, Standard of Care

Humber River Hospital. Consent to Investigation, Treatment or Operation

Humber River Hospital. Flumazenil. Parenteral Drug Manual

Appendix A

Post anesthesia recovery discharge score (Aldrete) PHASE I Recovery

Parameter	Variables	Score
Respiration	Able to take deep breaths and cough	2
	Dyspnea/ shallow/limited breathing	1
	Apnea	0
Circulation	Blood pressure +/- 20 mmHg from pre-op	2
	Blood pressure +/- 20 to 50 mmHg	1
	Blood pressure more than +/- 50 mmHg	0
Consciousness	Fully awake	2
	Arousal on calling	1
	Not responding	0
Activity	Moves 4 extremities	2
	Moves two extremities	1
	Moves 0 extremities	0
Oxygenation	O2sa more than 92% in R/A	2
	O2Sa with O2 more than 90%	1
	O2sa with O2 less than 90%	0

Appendix B

Modified PADSS Discharge Criteria: PHASE 2 Recovery

Parameter	Component	Score
Vital signs	Within 20 % range of pre-op value 20-40% of pre-op value More than 40% of pre-op value	2 1 0
Activity level	Steady gait / no dizziness/ consistent with pre-op level Ambulates with assistance Not ambulating/ dizziness	2 1 0
Nausea and Vomiting	Minimal, treated with PO medication Moderate , treated with parenteral medication Continues after repeat treatment	2 1 0
Pain	None/Mild discomfort/ acceptable to patient Acceptable to patient / treated with PO/ parenteral medication Pain not acceptable to patient	2 1 0
Post Procedural Bleeding	Minimal Moderate Severe bleeding-**notify GI immediately**	2 1 0